Department of Health Care Policy and Financing

Introduction

The Department of Health Care Policy and Financing (HCPF) develops financing plans for public health care programs. In Fiscal Year 2001, HCPF spent about $2.3 billion to administer its programs including Medicaid and the Children's Basic Health Plan. Please refer to page 35 in the Financial Statement Findings section for additional background information.

The following comments were prepared by the public accounting firm of BKD, LLP, who performed audit work at the Department of Health Care Policy and Financing.

Ensure Costs Are Allowable

Under the federal Medicaid program, certain expenditures are considered allowable costs and thereby qualify for reimbursement by the federal government. Total Medicaid program expenditures, excluding administrative costs, were over $2.1 billion for Fiscal Year 2001, which represents a federal share of just over $1 billion. The audit tested a stratified sample of 127 program expenditures and credits with a net value of $3,790,882 (federal share $1,895,441) for allowability under Medicaid regulations.

The types of errors identified in the sample continue to be similar to those found during the previous two fiscal years' audits. Overall, evaluation of the sample identified 51 program expenditures that did not comply with one or more of the allowable cost criteria for the Medicaid program. These 51 items had a value of $44,681 (federal share $22,341). The errors were as follows:

- **Electronic Data Interchange Agreements and Adequate Support for Claims**. There were 43 out of 127 instances in which no Electronic Data Interchange agreement for the billing provider was available for our review. By not confirming these agreements are in place with providers, the Department does not adequately ensure providers are aware of their obligation to have medical records to support the claims submitted. Payments for claims unsupported by medical records are not allowed under the Medicaid program.

- **Prescription Credits**. There were 6 of 11 sample items in which documentation was not present to indicate whether prescriptions were picked up by the Medicaid recipient within the prescribed 14-day period. Regulations allow the costs for prescriptions to be billed only if the recipient obtains the prescription within 14 days. Should a recipient not pick up a prescription within that time frame, the provider is required to credit the original cost back to the program. This requirement is stated clearly in the Pharmacy Provider Manual supplied by HCPF.

  Effective June 1, 2000, HCPF approved an amendment to the pharmacy provider agreements requiring that the provider maintain a log documenting the signature of the Medicaid recipient and the date the prescription was picked up. During our testing in Fiscal Year 2001 it was evident that some pharmacy providers were unable to provide this documentation for sample items. The Department intends to establish procedures to monitor and periodically test the pharmacy signature logs during Fiscal Year 2002 to ensure the Medicaid program receives credit for prescriptions not claimed within 14 days.

- **Transportation Claims**. There were two nonemergency county transportation claims tested. Both were billed directly by the transportation provider rather than by the appropriate county as required. Further, the services required prior authorization; however, approval occurred on a trip sheet submitted after the date of services. Additionally, two nonemergency Home and Community Based Services (HCBS) transportation services did not have documentation supporting prior authorization of the services.

- **Private Duty Nursing**. The one home health private duty nursing claim reviewed was for services that require prior authorization. No prior authorization was on file. The Department indicates that it subsequently made a change to the State's automated data processing system for payment of Medicaid claims; this change will require prior authorization before payment on these types of claims occurs. However, this error is further evidence that the Department should conduct the automated data processing reviews to ensure adequate internal controls are in place over claims processing for Medicaid. Currently only limited reviews are taking place. This issue is discussed further in Recommendations No. 39, 45, 46, and 47 below. (CFDA Nos. 93.777, 93.778; Medicaid Cluster; Allowable Costs.)

Recommendation No. 38:

The Department of Health Care Policy and Financing should ensure payments are made only for allowable costs under the Medicaid program by:

a. Ensuring that Electronic Data Interchange agreements are current for every provider submitting batch transactions before payment is made for those claims.

b. Establishing procedures to randomly test pharmaceutical providers' compliance with established requirements of maintaining chronological logs of the Medicaid recipient signatures and following up, as appropriate, to ensure credits are received for prescriptions not claimed within 14 days.

c. Reviewing and revising procedures for processing transportation claims to ensure only authorized transportation services are provided and paid.

d. Establishing and documenting reviews of the Medicaid claims processing system to ensure all services requiring prior authorization are screened for receipt of authorization before payment is made. The list of such services should be updated on a recurring basis.

Department of Health Care Policy and Financing Response:

a. Agree. Updating the Electronic Data Interchange agreements is part of the five-year provider reenrollment plan scheduled for completion by July 1, 2005. The Department is currently in the process of updating the Primary Care Physician's Electronic Data Interchange agreements. The current provider application incorporates the Electronic Data Interchange agreement so that all providers enrolling must sign the form. The agreements will need to be modified when the Health Insurance Portability and Accountability Act is implemented. The absence of an Electronic Data Interchange Agreement is a documentation issue and does not alter the correct processing and edit checks through the Medicaid Management Information System; it does not directly indicate improper payments.

b. Agree. Beginning in the third quarter of Fiscal Year 2002 the Program Integrity Unit will begin random yearly reviews of a sample of pharmacy

providers. Each review will encompass a 3-month time period and assess the provider's compliance in maintaining an accurate prescription receipt log. Compliance to claims reversal will be evaluated when prescriptions have not been picked up from the pharmacy within 14 calendar days. Appropriate provider education and/or demand letters for recovery of overpayments less than $200 will be issued at the conclusion of the review.

c. Agree. The Department has proposed revised transportation benefit rules which are to be presented to the Medical Services Board for first reading on November 9, 2001. If passed, they will go to second reading on December 14 with an effective date of February 1, 2002. The proposed rules provide clarification on the correct procedures for obtaining prior authorization for transportation services.

   The Department is issuing a Request for Proposal (RFP) for a statewide transportation broker to be implemented by July 1, 2002. The transportation broker will provide the prior authorization for non-emergent transportation, provide the reimbursement for transportation services, and maintain the administrative oversight and reporting for non-emergent transportation. Transportation claims for non-emergent transportation will no longer be processed through the fiscal agent once the transportation broker is implemented.

d. Agree. The Department continues to work with the fiscal agent to ensure that the Medicaid Management Information System has edits designed to prevent payment for unauthorized services. The Department will review these edits to ensure they are being set properly. Further, the Department will review the service codes that are to be prior authorized to ensure that the authorization indicators are set correctly. Completion scheduled for April 2002.

Perform Reviews of Controls over Automated Systems

The Medicaid program is dependent on extensive, complex computer systems and the internal controls over such systems for ensuring the proper payment of Medicaid benefits. Federal regulations (45 CFR 95.621) require state agencies to establish and maintain a program for conducting a biennial risk analysis and security review of automated systems for the Medicaid program. The purpose of these requirements is to ensure that

appropriate, cost-effective controls and safeguards are incorporated and operating as intended in Medicaid claims payment systems. The Department contracts with a nongovernmental service organization that functions as the fiscal agent for the Medicaid program and is responsible for the operation of the Medicaid Management Information System (MMIS), the automated claims processing system for the Medicaid program.

In both Fiscal Year 1999 and 2000, we found that the Department was not conducting the required biennial risk analysis and security review of MMIS. During the Fiscal Year 2001 audit, we noted that the Department had compiled policies for MMIS and had reviewed the physical security for the system. However, HCPF did not provide evidence that the biennial risk analysis had been performed.

In addition to meeting these federal requirements, the Fiscal Year 1999 and 2000 audits recommended that the Department ensure that an independent assessment of the internal controls over MMIS is performed on a regular basis. Our Fiscal Year 2001 audit noted that these reviews are still not taking place. The Department's continued lack of systematic testing of internal controls over MMIS creates concern about the accuracy of Medicaid payments. For example, many of the variables used in calculating Medicaid payments are input manually. If an error is made, claims may not be processed correctly. The need to test internal controls over MMIS was also addressed in the *Medicaid Management Information System Performance Audit* (May 2001, Report No. 1334) conducted by the Office of the State Auditor (see Recommendations Nos. 45, 46, and 47).

Because of the volume of claims processed through MMIS, it is critical that the Department ensure that data are secure, accurate, and safeguarded, and that internal controls are in place and operating as intended. On average, MMIS processes over one million claims each month. As mentioned earlier, expenditures for services under the Medicaid program were about $2.1 billion in Fiscal Year 2001.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Special Tests and Provisions (Automated Data Processing)).

Recommendation No. 39:

The Department of Health Care Policy and Financing should ensure adequate controls are in place over automated systems for the Medicaid program by:

a. Performing and documenting biennial risk analysis for the MMIS and following up on any corrective action deemed necessary as a result of that analysis.

b. Implementing a regular, systematic, independent assessment of controls over the Medicaid Management Information System.

Department of Health Care Policy and Financing Response:

a. Agree. The Department will conduct a risk analysis of the Medicaid Management Information System during Fiscal Year 2002. The analysis will be done in conjunction with the annual security review.

b. Agree. The Department currently conducts regularly scheduled claim processing assessment reviews. In addition, new controls over edit resolutions and reference file changes have been implemented. During Fiscal Year 2001 the Office of the State Auditor conducted a performance audit of the Medicaid Management Information System. The recommendations of the audit are currently being implemented. The fiscal agent is planning an independent assessment of controls for its data facility for Calendar Year 2002.

Improve Oversight Over Eligibility

The audit reviewed the Department's procedures for complying with federal requirements for determining the eligibility of the individuals who receive benefits and the providers who receive reimbursements under the Medicaid program. HCPF has established an agreement with the Department of Human Services (DHS) to oversee the determination of individuals' eligibility for Medicaid through county departments of social services. These departments are under the oversight of DHS. County departments are responsible for inputting information related to individuals' eligibility into the Client-Oriented Information Network (COIN) system or the TRAILS system, which tracks and monitors beneficiary eligibility. The information in COIN and TRAILS is used by MMIS in determining whether or not a claim should be paid on the basis of the individual's eligibility.

For providers, HCPF contracts with its fiscal agent, a nongovernmental service provider, to determine providers' eligibility for receiving Medicaid payments. Nonetheless, under federal regulations the Department of Health Care Policy and Financing remains ultimately responsible for the Medicaid program. This means that HCPF must have controls in place to ensure compliance with state and federal regulations for all aspects of the Medicaid program, whether performed directly by the Department, or by another entity through contractual or other formal agreements. As mentioned above, in Fiscal Year 2001, HCPF

paid Medicaid benefits to various providers in excess of $2.1 billion on behalf of individual beneficiaries.

In Fiscal Year 2001 our audit identified beneficiary eligibility errors in 3.1 percent (4 of 127 items) of the transactions tested; that is, instances in which payments were made on behalf of individuals not eligible for Medicaid. This is an increase from the 1 percent error rate found in the transactions tested during the Fiscal Year 2000 audit.

In the area of provider eligibility, we continued to identify a significant number of instances in which the documentation of required licenses was lacking, as was the case in the prior audit.

Individual Eligibility

The audit tested individual eligibility for 127 expenditures by reviewing files from the county departments of social services and determining whether individuals' information was properly reflected in COIN. We identified four payment errors with a net value of $3,140 (federal share $1,570). Further, we noted that there was no documentation in any of the files indicating that HCPF had attempted to recover the overpayments. The errors are as follows:

- In two instances, file documents indicated that the beneficiaries were not eligible at the date of service. The information contained in COIN showed the beneficiaries were eligible, and therefore the claims were paid.

- In one instance, documents indicated that the individual was ineligible for Medicaid because his income exceeded the 300 percent eligibility level for Old Age Pension (OAP). The information contained in COIN indicated the beneficiary was eligible, and the claim was paid.

- In one instance, a beneficiary's date of death preceded the capitation payment date, and the claim was paid.

The Department reports that it does not perform random testing of eligibility across all program areas. Instead, through a federally approved pilot project, eligibility testing is targeted toward areas considered to be of high risk. However, under this approach the Department does not ensure that all areas are periodically tested for eligibility determination accuracy. In addition, periodic random testing would enable the Department to reevaluate its risk assessment.

According to federal regulations, individuals must be eligible for the Medicaid program in order to receive benefits (42 CFR Part 435, Subparts G and H). By not ensuring that client eligibility is accurately determined and ensuring that eligibility information in COIN is accurate, HCPF risks that benefits may be paid on behalf of ineligible individuals. If erroneous payments were made, HCPF would have to repay to the federal government any Medicaid monies previously reimbursed to the State for these individuals.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Eligibility (Client Eligibility).)

Recommendation No. 40:

The Department of Health Care Policy and Financing should strengthen controls over the eligibility process for individuals under the Medicaid program by:

a. Working with the Department of Human Services to implement control policies and testing procedures to ensure all county departments of social services are maintaining current and complete files for Medicaid-eligible beneficiaries.

b. Establishing control procedures to ensure claims are not paid for an individual who is ineligible for benefits and to ensure individuals no longer meeting eligibility requirements are disenrolled in a timely manner from the Medicaid program and any associated payments are recouped for benefits paid on behalf of ineligible individuals.

c. Performing periodic random testing of eligibility claims in conjunction with targeted reviews to ensure eligibility is being properly determined, documented, and reported.

Department of Health Care Policy and Financing Response:

a. Agree. The Department of Health Care Policy and Financing has been working with the Department of Human Services to coordinate county eligibility training and establish protocol for answering county eligibility questions. Additionally, the HCPF Eligibility Section is currently working on a Volume 8 state Medicaid rules revision project. The goal of this project is to revise the state rules related to determination and redetermination of

Medicaid eligibility to make the rules more clear and user-friendly. The revision of rules should be completed by August 2002.

b. Agree. The Department agrees that an error occurred with regard to recouping the capitation payment that was made on behalf of the deceased. The Department is committed to ensuring that Medicaid payments are made on behalf of eligible clients only. Under current Medicaid process, recipients are informed of their rights and responsibilities at the time of application. Current client responsibilities require that eligible families or individuals notify their county department of any change in household circumstance within 10 days. This applies to the death of a household member. In the error cited above, the family notified their county and the eligibility technician discontinued the case within the allowable time frame. Unfortunately, this occurred at the end of the month after the mental health capitation was issued.

With regard to the recoupment issue, under managed care, payment for services is issued prospectively, which creates a challenging situation for the Department, especially in the instances of birth and death. Because of the reliance on client reporting of those events, these situations usually require manual adjustments to payment. Currently, when the Department becomes aware of a payment that was made on behalf of a client who died, a manual transmittal is issued to recoup the payment. To further ensure that erroneous payments are recouped, the Department is modifying the Medicaid Management Information System to automate this recovery process. A change request detailing the need for a monthly, automated reconciliation was developed and submitted to the fiscal agent for implementation. The Department expects to have this process in place by December 2002.

c. Agree. As stated previously, since 1994 the Department no longer performs random testing of eligibility. Instead, it targets specific areas for testing, otherwise known as Quality Control pilots. The Center for Medicare and Medicaid Services, formally known as the Health Care Financing Administration, gives states the option of fulfilling the federal Medicaid Eligibility Quality Control (MEQC) requirements by either traditional case reviews or pilot projects. The purpose of MEQC reviews is to effectively identify and reduce erroneous payments. Colorado chose the pilot option because it allows the Department to apply our expertise in Medicaid eligibility to focus our QC reviews and resources on areas where errors are more likely to occur.

The Department recognizes the value of randomized sampling; however, the federal pilot standards require all of our current MEQC resources. The Department is in the process of developing a sampling methodology for the Colorado Benefits Management System (CBMS) that will allow us to more readily sample all eligibility categories. We anticipate that this sampling will be in place by August 2002.

Provider Eligibility

The Department has contracted with its fiscal agent to determine the eligibility of providers to receive reimbursement for services under the Medicaid program. As part of this, the fiscal agent is required to maintain documentation to support that the medical providers are licensed in accordance with federal, state, and local laws and regulations (42 CFR sections 431.107 and 447.10; Section 1902(a)(9) of the Social Security Act).

Out of the sample of 127 Medicaid expenditures, the audit found 86 instances of provider eligibility errors related to lack of documentation of required licenses and registrations. In some cases more than one type of error was identified with a particular provider. The total value of payments made to providers in the sample for which one or more errors were identified was $977,461 (federal share $488,731). The audit identified the following errors:

- 29 provider files did not contain a signed copy of the provider agreement. According to federal regulations (42 CFR §431.107), there must be an agreement between the state Medicaid agency and each provider furnishing services for which reimbursement is claimed.

- 71 provider files lacked documentation of one or more required licenses.

- 16 hospital, long-term care, and intermediate-care facilities lacked documentation of certification to operate in accordance with the State's health and safety standards from the Department of Public Health and Environment.

In response to our audit recommendation in this area last year, HCPF indicated that it would develop a five-year reenrollment plan for providers to address these types of problems and improve documentation of provider eligibility. During Fiscal Year 2001 the Department established a provider enrollment committee that is responsible for developing a strategic plan for provider reenrollment. The Department has terminated providers with unknown addresses, providers with only post office box addresses, and providers with no

claim activity for the past three years. The Department has initiated a Primary Care Physician reenrollment process that requires updated provider agreements and proof of licensure; this information is being entered into MMIS. Finally, the Department is reviewing licensing information from the Department of Regulatory Agencies, and if licenses are expired, revoked, or inactive, the providers are terminated in MMIS.

If payments are made to ineligible providers, the Department would have to refund monies previously reimbursed to the State by the federal government. Therefore, the Department should continue efforts to ensure that the fiscal agent meets requirements related to provider eligibility. (CFDA Nos. 93.777, 93.778; Medicaid Cluster; Provider Eligibility (Special Tests and Provisions).)

Recommendation No. 41:

The Department of Health Care Policy and Financing should improve controls over provider eligibility by:

a. Requiring the fiscal agent to review all provider files to ensure each file includes a current provider agreement and documentation of applicable provider licenses and registrations.

b. Revising control procedures to ensure expenditures are made only to eligible providers.

c. Formalizing a written five-year strategic corrective action plan detailing the goals, milestones, and time frames for completion of the procedures to accomplish provider reenrollment.

Department of Health Care Policy and Financing Response:

a. Agree. The Department continues to work on a five-year provider reenrollment plan to update provider files, which is scheduled for completion by July 1, 2005. A strategic plan has been developed and implemented for this project.

b. Agree. As part of the five-year plan, the Department is currently updating provider files manually and electronically. Providers found not to be eligible

are terminated from the Medicaid program. The Department will implement additional control procedures by summer 2002.

c. Agree. The Department has developed and implemented a five-year strategic plan for provider reenrollment as noted above. In order to update the provider files in the most cost-effective manner, the Department has organized a provider reenrollment group that is pursuing several areas. The strategic plan has goals and target dates. The Department will continue to update and refine the plan. As noted in the audit report, the Department has accomplished several tasks the past fiscal year as part of the five-year plan.

Maintain Adequate Documentation in Case Files

The audit included tests on case files maintained by the Program Integrity Unit (PIU). This Unit investigates and attempts to recover overpayments under the Medicaid program. We identified one instance in which documentation in the case file indicated the case was closed to recovery, but the case had been closed without any evidence of recovery. The Department reports that the case file was backlogged since 1998 and was reviewed in May 2001 by a recovery agent. The recovery agent determined the case was unrecoverable, since the recovery amount could not be substantiated in 2001. When a case is closed for recovery, it is imperative that the recovery efforts be timely to ensure actual amounts are recovered and any backlogs are minimized.

In addition, of the 30 case files reviewed, we noted 2 files were missing required signatures and documentation of case disposition. HCPF should ensure all documentation is included in case files in accordance with the established Quality Assurance Policy and Procedures to ensure program integrity activities are properly carried out. (CFDA Nos. 93.777, 93.778; Medicaid Cluster; Special Tests and Provisions (Fraud & Program Integrity).)

Recommendation No. 42:

The Department of Health Care Policy and Financing should improve documentation of program integrity cases by:

a. Evaluating recovery procedures to ensure all cases are handled consistently and timely.

b. Requiring that case files contain all required supporting documentation of approvals and dispositions.

Department of Health Care Policy and Financing Response:

a. Agree. The backlog addressed above has been eliminated. This should prevent any delays in processing recoveries in the future.

b. Agree. The two cases where missing signatures and documentation were noted were opened in 1997 as part of a special study. At that time parameters for special study case reviews would be identified. As long as the terms of the study were satisfied, not all cases with recoveries were signed by the supervisor. Since this time the Quality Assurance Section has developed policies and procedures for all the major activities conducted by Program Integrity. This includes policies on case openings, the organization of case files, provider reviews, and the recovery of overpayments for disallowed services. This should ensure that all cases opened after April 2001 are handled consistently.

Determine Proper Rating for CBHP Beneficiaries

The audit tested a sample of 30 expenditures for the Children's Basic Health Plan (CBHP). We found that in one instance the beneficiary's income was miscalculated and an incorrect rating was assigned. The error did not result in the beneficiary being improperly determined as eligible, and the beneficiary enrolled during a period when premiums for the program had been suspended. Therefore, there was no monetary effect from the error. However, this type of error could result in inappropriately enrolling ineligible individuals in the program.

The Department contracts with a private nonprofit organization to administer the Children's Basic Health Plan, including the performance of eligibility determination. As of Fiscal Year 2001, the Department is requiring the contractor to obtain an audit under the federal Single Audit Act. Therefore, annual audit procedures at the contractor will include testing for compliance with federal and state laws and regulations, such as those for CBHP. (CFDA Nos. 93.767; State Children's Health Insurance Program; Eligibility.)

Recommendation No. 43:

The Department of Health Care Policy and Financing should improve documentation of eligibility for the Children's Basic Health Plan by requiring periodic reviews of eligibility determinations of those enrolled and those denied to test ratings and ensure proper enrollment into the program.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees that documentation should be strong. The Department already has strong quality assurance measures in place. The Department of Health Care Policy and Financing contractually requires the Children's Basic Health Plan administrative services contractor, Child Health Advocates, to document all eligibility policies and procedures. Current policy and procedures manuals are maintained by the contractor and approved by the Department. In addition, the Department has required that Child Health Advocates complete a monthly quality assurance review of eligibility determinations since Fiscal Year 1999. During the review, the contractor randomly selects at least 40 applications each month and ensures that the eligibility determination, whether enrolled or denied, was correct and that all data entry for the record was correct. The contractor is required to maintain an eligibility determination accuracy rate of 90 percent. The contractor reports its findings to the Department with its monthly reports. During Fiscal Year 2001 the contractor reviewed 480 individual files and reported a 98.96 percent accuracy rate for eligibility determinations. The Department also increased its oversight of CBHP eligibility determination with the additional requirement that Child Health Advocates have a Single Audit annually beginning with the year ending June 30, 2001. This audit will include eligibility testing by the independent auditors.

Subrecipient Monitoring of Single Entry Points

The Department of Health Care Policy and Financing is responsible for monitoring the performance of its single entry point (SEP) subrecipients, and the Department has entered into an Interagency Agreement with the Department of Human Services (DHS) to oversee the SEPs. SEPs are responsible for assessing what types of community-based services

are appropriate for individuals eligible for long-term care under the Medicaid program. Some of the options available include Home and Community Based Services, the Home Care Allowance program, and the Adult Foster Care program.

HCPF's current agreement does not require DHS to use a systematic or rotating time frame for completing on-site financial compliance reviews of SEPs or ensure that all SEPs are reviewed within a reasonable period of time. During the audit we found that some SEPs had not had a financial compliance review in five years. Without performing regular reviews, HCPF cannot ensure that beneficiaries are receiving appropriate long-term care services. (CFDA Nos. 93.777, 93.778; Medicaid Cluster; Subrecipient Monitoring.)

Recommendation No. 44:

The Department of Heath Care Policy and Financing should modify its Interagency Agreement with the Department of Human Services for single entry point subrecipient monitoring by:

a. Establishing procedures for conducting risk assessments of each single entry point entity and evaluating the need for an on-site financial compliance review.

b. Requiring that all single entry point entities receive an on-site financial compliance review within a reasonable period of time to ensure new and revised financial policies and procedures are being followed.

Department of Health Care Policy and Financing Response:

a. Agree. The Department will establish a procedure for prioritizing on-site financial compliance reviews that will improve financial compliance by recovering identified unspent or inappropriately spent case management payments. The Department will develop a risk-based prioritization for financial compliance reviews by July 1, 2002, for implementation of the Fiscal Year 2003 round of financial compliance reviews to be conducted by the Department of Human Services.

b. Agree. The Department will work through the budget process to procure the additional funds needed to conduct 12 on-site financial compliance reviews

annually, with each SEP being reviewed at least once every three years. Pending legislative approval, this will be implemented July 1, 2004.

Oversight of the Medicaid Management Information System

As part of its Medicaid plan, each state is required by federal regulations to have an automated claims processing and information system, referred to as the Medicaid Management Information System (MMIS). The Department of Health Care Policy and Financing is responsible for MMIS, since all Medicaid claims are paid through this system. HCPF contracts with Affiliated Computer Systems, Inc. (ACS; formerly Consultec, Inc.), to serve as the State's fiscal agent for the Medicaid program. ACS is responsible for claims processing through MMIS and ensuring payments are appropriate. The Department anticipates that ACS will be paid about $12.7 million in Fiscal Year 2001 to perform these services. During this period, MMIS is expected to process almost 13 million claims totaling about $2 billion on behalf of an average monthly Medicaid caseload of about 288,600 individuals.

Out of the over one million claims submitted by providers and processed through MMIS each month, approximately 95 percent are electronic and 5 percent are paper. This does not include the monthly capitation payments to managed care organizations, including HMOs. Paper claims are manually keyed into MMIS, at which point they are processed in the same manner as electronic claims.

As claims are processed through MMIS, they are "reviewed" by a complex series of approximately 700 system edits designed to ensure payments are accurate and allowable under the Medicaid program, based on the type of claim and service and other factors. As claims are processed, they are "flagged" by edits to be either paid, denied, or placed into suspense; these settings are referred to as "edit dispositions." The fiscal agent's claim technicians manually resolve suspended claims by using on-line "edit resolution text," which outlines the appropriate action to take for the particular claim. Once edits are resolved, the claim is placed back into the processing queue. Each Friday, provider payment records, based on claims approved for payment, are uploaded from MMIS into the State's financial system. Payments are issued to providers by warrants or electronic fund transfers.

In Fiscal Year 2001 the Office of the State Auditor and Buck Consultants conducted a performance audit of the Medicaid Management Information System. The audit comments below were contained in the *Medicaid Management Information System, Department*

of Health Care Policy and Financing Performance Audit, Report No. 1334, dated May 2001.

Mechanisms for Monitoring Accuracy

One of the key performance measures for claims processing is accuracy. "Accuracy" in this context refers to whether paid claims are accurately calculated and are allowable under state Medicaid policy. In other words, only claims for permitted services are paid, services must be provided to an eligible individual, and the claim must be paid to an eligible provider. Our audit found that while HCPF has numerous processes in place for overseeing the fiscal agent's activities and claims processing, the Department lacks adequate, systematic methods for ensuring and monitoring accuracy of claims payment. Our analysis indicates the need for improvement in this area to ensure all Medicaid claims payments are appropriate.

The Department reports that its most recent claims audit (October 2000) of MMIS showed a financial error rate of less than 1 percent; this is within the industry standard for financial error rates in an automated claims processing environment. The financial error rate is the absolute value of payment errors in the sample divided by the dollars paid for all claims in the sample.

As part of our audit, Buck Consultants tested a random sample of 150 suspended claims in MMIS to evaluate the quality and efficiency of claims processing. The auditors found that 26 claims (17.3 percent) had some type of error that occurred because of a mistake made during processing. While there is no industry standard for a tolerable error rate on suspended claims, there is general agreement that an error rate of 17.3 percent is unacceptably high. Buck Consultants noted that suspended claims have already been subject to the fiscal agent's data entry quality assurance procedures, which should have identified and corrected the great majority of the errors identified.

We noted the following concerns with the Department's mechanisms for monitoring accuracy for claims processed in MMIS.

Claims Audits Performed by HCPF

While the Department receives feedback from its program personnel and from providers when there are problems with claims processing, its most direct and systematic means of monitoring the accuracy of claims processing is the performance of claims audits by IS Section staff. Until 1996, the federal Health Care Financing Administration (HCFA) mandated that claims audits be performed on a routine basis; states may now perform these reviews at their discretion. HCFA permits states to receive federal matching funds

for the performance of the claims audits. The Department has elected to continue performing claims audits. We agree that continuing the audits is important because, ultimately, the federal government will hold the State responsible for amounts paid through the Medicaid program and require settlement for any improperly paid claims.

While the Department has taken a positive step by continuing the audits, it needs to use this tool in a more effective and systematic manner to ensure the audits detect and prevent errors in processing. We noted the following:

- The Department has not established specific measurable goals for accuracy of payment, either for the fiscal agent or for the Department itself.

- The Department has not ensured that claims audits are completed on a routine basis. Only three audits on samples of paid claims have been performed since the installation of the new MMIS on December 1, 1998. These audits should be performed at least quarterly. In addition, the audits should test for timeliness of payment, since the fiscal agent is required to meet timeliness requirements under the contract.

- The Department has not reported financial error rates that reflect all errors identified in the claims audits. The reported rates reflect only errors attributable to the fiscal agent. The overall financial error rate reflecting errors attributable to both the Department and the fiscal agent should be calculated. This overall rate would reflect the extent to which payments are accurate and in accordance with Medicaid policy. For example, the March 2000 claims audit reported a financial error rate of 4 percent for the fiscal agent. However, the rate reflecting all errors, regardless of source, would have been 10.4 percent. As noted earlier, the industry standard in an automated claims processing environment for the financial error rate is 1 percent or less. In addition, the Department should calculate a procedural error rate during the claims audits. This is another type of benchmark commonly used in automated claims processing environments.

- The Department has not formally communicated the results of claims audits to the fiscal agent and to HCPF staff and ensured that corrective action plans are developed and implemented.

The Medicaid program is the largest federal program administered by the State, with expenditures at approximately $2 billion annually. The Department should take stronger measures to ensure that payments for services under this program are accurate and allowable under the Colorado Medicaid program.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Allowable Costs.)

Recommendation No. 45:

The Department of Health Care Policy and Financing should ensure claims processed through MMIS are accurate and allowable under the Medicaid program by:

a. Establishing performance measures for claims processing in terms of financial and procedural error rates.

b. Conducting regular claims audits on at least a quarterly basis. Timeliness of processing should be included in the testing procedures.

c. Reporting all errors and problems identified in the claims audit, regardless of source, and calculating procedural and financial error rates both for the fiscal agent and for claims processing overall.

d. Ensuring corrective action plans are developed and implemented in a timely manner by both fiscal agent and Department staff for all issues identified in the claims audits.

Department of Health Care Policy and Financing Response:

Agree.

a. The Department will work on developing appropriate standards that include measures for procedural error rates. The Department will establish the performance measures for the next scheduled Claims Processing Assessment System (CPAS) review for claims paid in June 2001.

b. Quarterly reviews are already being done. The timeliness calculation will begin with the next internal review process. To be completed by September 15, 2001.

c. The CPAS audit report will be enhanced to include newly defined procedural and financial error rates. To be completed by September 15, 2001.

d. The Department has already begun work in ensuring corrective action plans are developed and implemented. Issues from CPAS audit reports are being

developed into recommendations for the fiscal agent when appropriate. Referrals to Department staff will now include more information to allow for adequate follow up. The Department will take corrective actions on the recommendation as quickly as resources allow.

Quality Assurance Procedures Performed by the Fiscal Agent

The fiscal agent's Quality Assurance (QA) initiative has two components: internal programs run by several units in their own areas and the formal QA program run by the QA unit. In terms of claims processing, procedures performed by the QA unit are limited and consist only of tests over the processing of paper claims through the point at which the claims are manually keyed into MMIS. Paper claims represent about 5 percent of all claims submitted.

In terms of data entry of paper claims, QA staff review 10 percent of all paper claims manually keyed into MMIS by "exam entry" staff. Prior to this formal QA review, the exam entry unit itself reviews 50 percent of all data-entered claims. Thus, the data entry function on paper claims is reviewed twice. The purpose of both these procedures is to ensure paper claims are accurately entered into MMIS. Once paper claims are keyed into MMIS, they are processed identically to electronic claims.

The QA unit does not test a sample of paid claims to ensure payments are accurate and allowable under the Medicaid program.

Results of Tests Performed by Buck Consultants

As mentioned earlier, Buck Consultants tested a sample of 150 suspended claims during its audit at the fiscal agent and found a procedural error rate of 17.3 percent (26 claims). A procedural error is a claim containing one or more mistakes in the calculation of amounts payable on the claim, or in fields that potentially affect the calculation or management reporting of data, such as an error in a diagnostic code. Although procedural errors may not directly affect accuracy of payment, a high procedural error rate such as 17.3 percent indicates problems with the claims processing function.

Buck Consultants found that the errors were attributable to two causes. First, most of the errors (19 out of 26) were paper claims that had been inaccurately keyed into MMIS.

This is a concern because paper claims processed to the point of suspense have already been subject to two levels of QA reviews. This indicates the fiscal agent's quality assurance procedures over data entry of paper claims are not effective. The high error rate also presents the risk that other data entry errors may be occurring and are not being detected when the errors do not cause the claims to suspend. Finally, undetected data entry errors increase the volume of suspended claims. This means claim technicians must spend more time resolving claims, thereby driving up administrative costs, processing times and, more importantly, delaying payments to providers.

The second source of errors (7 out of 26) was errors made because of problems with the edit resolution process: the technicians did not use the appropriate edit resolution text to resolve the claim, a duplicate claim was overlooked and approved for payment, and a claim was approved for payment when there was a private insurance carrier listed as a third-party resource. Since Medicaid is the payer of last resort, the claim should have been returned to the provider for submission to the carrier. In two other instances there were no resolution instructions available online for the claim technician to use for resolving the edit that caused the claim to suspend.

Factors Affecting Error Rates

Buck Consultants also identified several factors that can contribute to high error rates. First, the fiscal agent's claims processing staff had a high turnover rate (about 45 percent from July through December 2000). Second, the fiscal agent's training program is not as comprehensive as programs offered by other claims administrators. The fiscal agent provides three months of training, which is a combination of classroom and on-the-job training; other administrators provide two to three months of formal classroom training, and processors are in training status for six months. Third, the fiscal agent has set very high production requirements. Claims technicians are expected to resolve 500 claims per day after six months of experience; this calculates to less than a minute per claim based on an eight-hour day. This is not sufficient time to adequately review and process a payment and may explain why technicians do not always use the appropriate resolution text. Most administrators require claims processors to resolve 75 to 100 suspended claims daily.

Improvements to Quality Assurance Function

The results of the audit by Buck Consultants indicate the need for the fiscal agent to improve the QA function over both the exam entry and edit resolution processes. As part of this the fiscal agent should expand its QA function to include audits on a sample of paid claims. Buck Consultants reports that in a commercial automated claims processing

environment, standards require that 3 percent of the volume of processed claims be audited. Overall, the Department needs to ensure that the QA process at the fiscal agent functions as an effective tool for maintaining accuracy of claims processing. Further, HCPF should work with the fiscal agent to ensure that production requirements for claims technicians do not have an unacceptably high impact on processing accuracy.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Allowable Costs.)

Recommendation No. 46:

The Department of Health Care Policy and Financing should ensure claims processed through MMIS are accurate and allowable under the Medicaid program by requiring that the fiscal agent:

a. Expand quality assurance procedures for testing the accuracy of data entry on paper claims and report results to the Department. The Department should monitor results to ensure satisfactory data entry performance is achieved.

b. Conduct regular audits of paid claims on a defined percentage of processed claims and report the results to the State. The Department should monitor results against the performance measures established under Recommendation No. 45.

c. Increase oversight of edit resolution claim technicians and reassess production requirements to ensure suspended claims are appropriately resolved. In particular, the fiscal agent should ensure that all required resolution text is available and appropriately applied to claims and claims with third-party resources are returned to providers for submission to those parties.

Department of Health Care Policy and Financing Response:

Agree.

a. The Department will begin work with the fiscal agent to expand quality assurance procedures for testing the accuracy of data entry of paper claims by September 1, 2001.

b. The Department will work with the fiscal agent to have it use the Claims Processing Assessment System (CPAS) for its own auditing purposes. Results will be measured against the standards established in Recommendation No. 45. The Department will work with the fiscal agent to begin the audits by September 2001.

c. Although the fiscal agent currently employs quality assurance activities over edit resolution technicians, the Department will work with the fiscal agent to establish a plan for achieving further oversight and increased accuracy by August 1, 2001.

Review of Edits and Edit Resolution Text

The Department and fiscal agent staff have initiated a review of all edits, edit dispositions, and the edit resolution text. The Department acknowledges that prior to implementation it was not able to adequately review the approximately 700 edits in the new MMIS. The purpose of the review would have been to ensure that the edit dispositions were correct and that the resolution text contained appropriate instructions for claim technicians to use during the edit resolution process of suspended claims.

The lack of an adequate initial review has been a concern because the edits in MMIS were brought in from another state's MMIS, while the edit resolution text was brought in from Colorado's previous MMIS. The Department and the fiscal agent report that a number of problems have resulted from the fact that the edit resolution text does not always appropriately match the edits in the new MMIS. Additionally, inappropriate edit dispositions themselves have in some instances contributed to inaccurate payment of claims and high volumes of suspended claims.

In July 2000 the Department and the fiscal agent embarked on a review of all edits, edit dispositions (e.g., pay, deny, suspend, ignore), and the associated edit resolution text. This review has not yet been completed. The Department reports that it plans to complete this task in May 2001; however, documentation provided to us indicates that fewer than 200 of the 700 edits in MMIS had been reviewed as of the end of our audit. It is critical that this task be completed as soon as possible. Until the review is finished and claim technicians have been adequately instructed to use the revised text, there should be heightened attention to accuracy of payment.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Allowable Costs.)

Recommendation No. 47:

The Department of Health Care Policy and Financing should establish the review of MMIS edits, edit dispositions, and edit resolution text as a high priority and work with the fiscal agent to complete this project as soon as possible. The Department should require that the fiscal agent conduct appropriate training and monitoring of claims processing staff to ensure changes are appropriately implemented.

Department of Health Care Policy and Financing Response:

Agree. The Department has established the edit review process as a high priority by having regular, weekly meetings. The fiscal agent operations staff and the State's business analysts have been utilizing these weekly meetings to address edits in a critical priority order. A schedule has been developed with completion defined in July 2001. The Department will require the fiscal agent to provide enhanced training and monitor staff for appropriate implementation of the edits by August 2001.

Controls Over MMIS Provider Database

As mentioned above, the Department of Health Care Policy and Financing contracts with a fiscal agent to operate MMIS and handle the processing of Medicaid claims through the system. Medicaid providers are required to submit claims to the fiscal agent for reimbursement. As of April 2001, almost 16,600 providers had submitted claims to the Medicaid program during the current fiscal year. Altogether, reimbursements to providers average about $148 million each month.

Medicaid providers include a broad range of professions and facilities. Under state and federal requirements, a Medicaid provider must have a valid license or certificate, as applicable, to furnish the goods or services charged to the program. HCPF is responsible for ensuring this requirement is met. The Department of Regulatory Agencies (DORA) and the Department of Public Health and Environment are responsible for issuing licenses and certifications and otherwise regulating the various types of providers as a whole in the State.

As part of the audit, we compared information from DORA on licensed professionals in the State for three of the major professions (physicians, pharmacists, and dentists) with the

provider database maintained on MMIS. Out of a sample of 131 providers, we found that 65, or just under half, currently had valid licenses; the remaining 66 did not. Because of the manner in which we chose our sample, these results are not indicative that a similar percentage of all MMIS providers lack licenses. However, these results do confirm that there are unlicensed providers in the MMIS database. Out of the 66 unlicensed providers, we found 7 that had received almost 580 payments totaling about $2,540. Individual providers received payments for periods ranging from 4 to 22 months. These seven providers all either had inactive licenses or had allowed their licenses to lapse.

We recognize that these are small amounts compared with total monthly program volumes of over a million claims and average monthly payments of around $148 million. Nonetheless, the identification of unlicensed providers in the provider database—along with the fact that, in some cases, payments were made to these providers—demonstrates that there are problems with provider data in MMIS. These problems can allow erroneous or fraudulent payments to be made in the Colorado Medicaid program.

Department Efforts to Improve Provider Data

The Office of the State Auditor has previously issued recommendations to HCPF directed at, among other things, the need to (1) verify licensing and other provider credentials and (2) perform periodic reenrollments of providers. The Department has made some progress in addressing these areas.

- **Reenrollment of providers.** The Department has begun a three-year phased reenrollment of the 1,700 Primary Care Physicians in the Medicaid program. The Department has not yet developed a plan for reenrolling other providers or a policy on frequency of reenrollment.

- **Deactivation of nonparticipating providers.** Recently the Department worked with the fiscal agent to identify providers that have not submitted claims in three years, and as a result, over 6,000 providers were placed on "inactive" status. The Department has not established a policy on how often deactivations will occur or what benchmark will be used in the future.

- **Data match project.** The Department has several staff working on matching licensing information from DORA with providers on MMIS. The process is highly manual because the two databases are not compatible, and the match is not yet completed. HCPF plans to electronically perform this match with data from DORA, but no time frame has been established for implementation and no policy has been established for how often the match would be performed. Many professional licenses must be renewed every two years.

Overall, the Department has undertaken several important initiatives to improve the quality of provider data. These should assist with detecting and preventing improper Medicaid payments. The Department should ensure these efforts are fully implemented and utilized by formalizing policies and procedures, establishing time frames, and monitoring completion of these tasks.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Allowable Costs.)

Recommendation No. 48:

The Department of Health Care Policy and Financing should develop and implement adequate controls over the provider database in MMIS by establishing formal policies, procedures, and time frames for the following:

a. Routine reenrollment of Medicaid providers.

b. Deactivation of providers who have not submitted claims to the Medicaid program for specified lengths of time.

c. Periodic data matches on provider credential information with other state agencies that regulate Medicaid providers.

The Department should monitor all of these projects to ensure completion.

Department of Health Care Policy and Financing Response:

Agree.

a. As mentioned in prior audit responses, the Department is working on a five-year plan for reenrollment. The five-year plan is scheduled to be completed by July 1, 2005. A reenrollment committee has been established and reenrollment activities have already begun. This committee will be addressing the issue of policy, procedure, and time frames for provider reenrollment. A strategic plan will be developed by August 1, 2001.

b. The Department conducted deactivation activities this year and will continue such activities on a yearly basis. Again, the committee will address the ongoing policy and procedures of this activity.

c. Periodic data matches, while technically possible, are extremely complex and manually time-consuming. Based on the current experience of matching data with the Department of Regulatory Agencies for eight types of practitioners, this has required a tremendous amount of manual verification. During Fiscal Year 2002 the Department will be investigating with DORA to determine how to resolve the differences in required unique key information to allow a possible electronic interface. This will allow the Department to update licensure information for prescribing physicians. Until there is an electronic solution, the manual process will be used as appropriate.

Role of Program Integrity Unit

The Program Integrity Unit, which is under the Quality Assurance Section at the Department, has the ongoing responsibility of obtaining information from several sources on providers that have been sanctioned as a result of disciplinary actions. These providers no longer have valid licenses and thus are ineligible to participate in the Medicaid program. The Program Integrity Unit receives and reviews information from several sources at the federal level and from the State Board of Medical Examiners. The Unit relays information about providers that can no longer participate to the Department's Contract Administrator, who furnishes it to the fiscal agent. The fiscal agent removes the provider from active status in MMIS.

While the information forwarded by the Unit serves an important role in maintaining the integrity of provider information, the Unit has not established routine communication procedures with other state regulatory boards at DORA in addition to the Board of Medical Examiners. For example, the Department does not receive regular updates on disciplinary actions from the Board of Dental Examiners, the Board of Pharmacy, the Board of Nursing, or the Board of Optometric Examiners; there are additional boards, as well, whose regulatory authority affects providers in the Medicaid program. While the Unit reports that it receives information from the federal level on providers other than physicians, the information would be more complete and timely if the Unit established routine communication with these other state boards. It should be noted that the information received by the Program Integrity Unit does not include providers that have changed their status to inactive or have allowed their license to lapse. Therefore, this communication does not fulfill the same function as performing a data match with DORA boards.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Allowable Costs.)

Recommendation No. 49:

The Department of Health Care Policy and Financing should establish routine communication on disciplinary actions taken by other state agencies that regulate Medicaid providers and ensure the provider database in MMIS is updated as appropriate.

Department of Health Care Policy and Financing Response:

Agree. By August 31, 2001, the Department will develop routine communication mechanisms with other state agencies to identify providers who should be terminated from the Medicaid program. The Department will terminate those providers from active status in the MMIS.

Certifications for Laboratory Providers

Medicaid regulations require that providers furnishing laboratory services must have a certification under the federal Clinical Laboratory Improvement Amendment (CLIA) program. The certification is intended to establish quality standards for all laboratory testing to ensure accurate, reliable, and timely patient test results across all facilities. The federal Health Care Financing Administration (HCFA) oversees the CLIA program. In Colorado the Department of Public Health and Environment (DPHE) conducts the CLIA certification process for laboratories on behalf of HCFA. Each certified provider is issued a CLIA number. Certifications also indicate the level of laboratory services the provider is permitted to perform. All providers of laboratory services, including physicians' offices that perform less complex laboratory work, are required to have some type of CLIA certification.

DPHE reports that there are about 2,500 CLIA-certified sites in the State. In Fiscal Year 2000 the State paid almost $8 million to providers for laboratory services under the Medicaid program.

During the audit the Department reported that CLIA certification numbers are routinely collected from appropriate providers and entered into MMIS. The MMIS system was developed with edits that were designed to ensure that claims for laboratory services are not paid unless the provider has the appropriate level of CLIA certification. However, the

Department reports that these edits have not worked properly since the implementation of the new MMIS, and therefore, the CLIA requirements are not being enforced. In other words, laboratory claims may be paid regardless of whether the provider has the necessary CLIA certification. The Department reports that the delay in correcting this problem is due to turnover in program staff with knowledge about CLIA requirements.

Although our audit did not identify instances in which laboratory claims were paid without evidence of required CLIA certification, the Department should ensure that this safeguard is operating appropriately in MMIS in order to prevent improper payments.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Allowable Costs.)

Recommendation No. 50:

The Department of Health Care Policy and Financing should implement edits in MMIS to review laboratory claims for compliance with CLIA requirements in accordance with state Medicaid policy.

Department of Health Care Policy and Financing Response:

Agree. The Department has recently hired a new policy person, who will review and address the Clinical Laboratory Improvement Amendment (CLIA) issues. This activity has started this month including review of policy, edit dispositions, and systems issues. A plan to address these issues will be completed by June 2001.

Home and Community Based Services and Home Health Services Overview

As an alternative to nursing facility care, Medicaid-eligible individuals who meet the functional assessment for needing nursing facility level of care can choose to receive supportive services in their home or an alternative living environment outside of a nursing facility. These supportive services are provided to individuals through the Home and Community Based Services (HCBS) and the Home Health programs. HCBS programs provide unskilled care in community settings. Unskilled care includes adult day care, personal care, homemaker services, and nonmedical transportation, among other services.

There about 1,100 HCBS providers (including those that are not overseen by the Department of Public Health and Environment's survey process). In Fiscal Year 2000 the HCBS program for the Elderly, Blind, and Disabled (HCBS-EBD) provided services to nearly 13,000 individuals at a cost of about $64.2 million.

In addition to the unskilled services provided by HCBS, skilled services are available through Colorado's Home Health program. Skilled services include skilled nursing, home health aid, occupational therapy, physical therapy, and speech pathology. There are about 131 home health (skilled) services providers. In Fiscal Year 2000 the Home Health program provided services to about 6,600 individuals at a cost of $66.9 million.

The Department of Health Care Policy and Financing is responsible for overseeing and administering all Medicaid programs, including HCBS and Home Health. The Department of Health Care Policy and Financing delegates some responsibilities for the HCBS and Home Health programs to other entities. The Department of Public Health and Environment (Health Facilities Division) is responsible for overseeing quality of care provided by HCBS and home health service providers. The Department of Human Services monitors the Single Entry Point agencies (SEPs). Consultec, a private corporation, serves as the State's Fiscal Agent, disbursing payments made for HCBS and home health services.

During Fiscal Year 2001 the Office of the State Auditor conducted a performance audit of Home and Community Based Services and Home Health Services. The audit comments below were contained in the *Home and Community Based Services and Home Health Services Performance Audit*, Report No. 1033, dated June 2001.

Controlling Costs

Costs for both home health (skilled) and HCBS (unskilled) care have risen dramatically in the past seven years, as demonstrated in the following table.

Change in Home Health and HCBS Expenditures Fiscal Years 1995 to 2001				
	Fiscal Year 1995		Fiscal Year 2001 (Projected)[1]	
	Total Expenditures (In Millions)	Cost per Person	Total Expenditures (In Millions)	Cost per Person
Home Health	$ 20.3	$3,742	$ 71.1	$10,555
HCBS	$ 18.4	$3,745	$ 73.1	$5,037

Source: Office of the State Auditor's Analysis of Data Provided by the Department of Health Care Policy and Financing's Budget Office.
[1] FY 2001 expenditures projected by Department of Health Care Policy and Financing staff.

The importance of controlling costs cannot be overstated. As the population ages and the cost of health care services rise, there will be increasing pressure on the limited dollars available in the State's budget for long-term care. It is critical that the Department of Health Care Policy and Financing has set up an appropriate fiscal control structure over both the Home Health and HCBS programs. One of the most important controls is setting appropriate limits on expenditures. Payment system edits and postpayment review also provide important controls in a fee-for-service environment.

As part of our audit, we reviewed overall costs, payment system edits, postpayment reviews; analyzed claims data using audit software; and discussed cost containment limits with other states. We found significant problems with the fiscal management of both the skilled and unskilled portions of community long-term care.

Cost of Serving Individuals in the Community

Colorado law requires that "home and community based services... shall be offered only to persons... for whom the costs of services necessary to prevent nursing facility placement would not exceed the average cost of nursing facility care...," Section 26-4-606, C.R.S. Additionally, the agreement with HCFA (federal Health Care Financing Administration) for the HCBS-EBD program states that:

> The state will refuse to offer home and community-based services to any recipient for whom it can reasonably be expected that the cost of home or community-based services furnished to that recipient would exceed the cost of [nursing facility] level of care.

During our review we found that current controls are not working to ensure that the cost of caring for individuals in the community is less than the cost of serving them in a nursing facility. Specifically, a review of all HCBS (unskilled) and home health (skilled) claims paid on behalf of those 3,300 HCBS participants (25 percent of the HCBS population) who also receive home health services revealed that for about 20 percent (673) of those clients, the cost of community care exceeded the cost of nursing facility care when their home health and HCBS services are combined. Assuming these 673 clients could be placed in a typical nursing facility, the HCBS and Home Health programs combined paid over $14.5 million more than the average cost of nursing facility care to serve these individuals in the community. As a result, HCPF not only is paying more to serve some individuals in the community than it would in a nursing facility but also is not in compliance with state statutes and federal agreements for the HCBS program.

Maximum Service Limits Are Set Too High

Currently the home health (skilled) and (unskilled) service limits combined total about $119,000 per year for community long-term care and $141,000 per year for acute care obtained in the community. These limits are about five and six times the average cost of serving an individual in a nursing facility, respectively. There may be reasons to approve costs above the upper payment limits in certain cases; however, Colorado's service limits are set so high that, effectively, they are not limits at all.

Other States' Limits Indicate Service Limits in Colorado Are Too High

We interviewed six other states for information on the limits they had set on unskilled (HCBS) care. The other states we interviewed did not have comparable types of limits on skilled care, and therefore, comparison of other state limits on skilled care is not included in this audit. We chose these states based on their location in our region or because they were known for having cost-effective HCBS programs.

Specifically, we found that of the six states we interviewed, three set annual dollar limits on unskilled care of about $5,000, $10,000, and $12,000 per person, per year. These limits are significantly lower than the $38,000 limit Colorado has set for HCBS services. The remaining three states had differing levels of need for which they had a range of dollar limits. For example, one state has several levels of care including a hospital level-of-care limit to ensure that individuals who would otherwise need to be cared for in a hospital can

be served in the community for less than ongoing hospital care. Additionally, a report issued by the American Association for Retired Persons (AARP) in 1996 states that for an HCBS program to be cost-effective, the limits on unskilled services in the community should be about one-fifth the cost of nursing facility care. In Colorado, this would be about $5,100 (as opposed to the current limit of over $38,000).

The federal government (specifically HCFA) has allowed states a lot of flexibility in setting up its HCBS and Home Health programs, including how states set limits on services to ensure that the overall per capita cost of the HCBS programs do not exceed the per capita costs of nursing facility care and that the amount of skilled services provided to individuals in their homes is appropriate. Further, state statute gives the Department of Health Care Policy and Financing the authority to set rules, including those pertaining to upper service limits.

HCBS Limits Are Set Higher Than the Average Cost of Nursing Facility Care

For the HCBS program, the Department set up program rules requiring that the community-based services provided to each qualified HCBS-EBD participant are less than or equal to the cost of nursing facility care. To do this, the Department set a monthly cost containment limit on the HCBS (unskilled) services for each program participant. This maximum dollar amount is reduced by the amount of Social Security Income (SSI) and other income a participant might have, as well as by the amount of Home Care Allowance the person receives.

For Fiscal Year 2000 the HCBS cost containment limit is set well above the actual cost of serving an individual in a nursing home, as is demonstrated in the following table.

HCBS Cost Containment Limits As Compared to Actual Costs of Nursing Facility Care[1] Fiscal Year 2000		
Annual Cost Containment Limit (Amount Allowed for Unskilled Care per Person)	**Actual Average Cost of Nursing Facility Care per Person for One Year[2]**	**Annual Cost Containment Limit for HCBS as a Percentage of the Average Cost of Serving Someone in a Nursing Facility**
$37,308	$25,530	146.13%

Source: Office of the State Auditor's analysis of data provided by the Department of Health Care Policy and Financing.
[1] Average cost containment limits and actual costs of nursing facility care do not include client contribution payments.
[2] Actual average cost of nursing facility care is based on average length of stay in nursing facility being 245 days times the average nursing facility rate of $104.20 per day.

As shown in the above chart, the HCBS cost containment limit is about 46 percent higher than the actual cost to serve an individual in a nursing facility.

Nursing facilities are paid a daily rate for serving each resident. This daily rate is to cover all skilled care, unskilled care, meals, and room and board needed by that individual. It is inappropriate to allow HCBS participants to receive unskilled services that alone are 46 percent more than the entire average cost of care in a nursing facility.

Service Utilization Indicates Limits Are Too High

On average, HCBS (unskilled) services provided to 65 of the 67 clients in our claims review sample were 61 percent, or about $17,000 per person, below the clients' personal cost containment limits (including reductions for the client's income and Home Care Allowance amounts). For the State as a whole, the average amount spent per HCBS participant in Fiscal Year 2000 was about $5,000, or 87 percent, below the cost containment limits. The fact that the limit on HCBS services could be lowered is also evident from the utilization data presented in the following table. This table demonstrates the stratification of service dollars paid on behalf of all clients receiving HCBS services.

Stratification of HCBS (Unskilled) Services Paid per Client for Clients Statewide[1] Fiscal Year 2000		
Range Dollar Amount HCBS Services	**Number of Clients**	**Percentage of Population Served**
$0 to $4,999	8,536	65.17%
$5,000 to $9,999	2,445	18.67%
$10,000 to $14,999	1,274	9.73%
$15,000 to $19,999	491	3.75%
$20,000 to $24,999	306	2.34%
$25,000 to $29,999	45	0.34%
$30,000 to $35,000	2	0.02%
TOTAL	**13,099**	**100.00%**

Source: Office of the State Auditor's analysis of Fiscal Year 2000 HCBS claims data. FY 2000 claims data is paid through November 2000.
[1] Does not include Home Modification Services, because those services are subject to a separate $10,000 lifetime limit.

As shown by the above table, 65 percent of all individuals served were served for less than $5,000. About 94 percent of all individuals served in the HCBS-EBD program were served for 60 percent or more below the cost containment limit in Fiscal Year 2000.

Home Health Limits Should Also Be Examined

For the Home Health program, HCPF has set the following limits on services:

Home Health Service Limits[1] Effective January 1, 2000		
	Daily Limit	**Annual Limit[2]**
Long-Term	$223	$81,395
Acute[3]	$285	$104,025

Source: Colorado Medicaid Program Billing Procedures manual.
[1] Limits do not include Private Duty Nursing.
[2] Calculated using the daily limit times 365 days.
[3] Acute home health is provided to a client when they have an immediate need for a service due to a sudden sickness or injury. Acute home health is not meant to be continued over the long term.

In other words, a person could receive more than $81,000 per year in skilled care in the community on a continual basis. This is roughly the equivalent of receiving skilled nursing services for three hours per day, every day, for an entire year. The home health limits can be exceeded under certain extenuating circumstances and with prior approval from Colorado Foundation for Medical Care (CFMC). The fact that home health limits should be lowered is evident from the service utilization data presented in the table below. This table demonstrates the stratification of home health services provided to all home health recipients.

Stratification of Home Health (Skilled) Services per Client for All Clients Receiving Home Health Care [1] Fiscal Year 2000

Range Dollar Amount Home Health Services	Number of Clients	Percentage of Population Served
< $15,000	5,515	83.02%
$15,000 to $29,999	525	7.90%
$30,000 to $44,999	314	4.73%
$45,000 to $59,999	194	2.92%
$60,000 to $74,999	62	0.93%
$75,000 to $89,999	28	0.42%
$90,000 to $104,999	2	0.03%
$105,000 to $135,000	3	0.05%
TOTAL	**6,643**	**100.00%**

Source: Office of the State Auditor's analysis of Fiscal Year 2000 home health claims data. FY 2000 claims data is paid through November 2000.
[1] Excludes Private Duty Nursing Services.

As shown in the above table, 91 percent of all home health recipients received services of less than $30,000 during Fiscal Year 2000. In other words, about 91 percent of all clients receiving home health were served for 63 percent or more below the daily limits on home health care. Less than one-half of 1 percent of all home health clients received services exceeding $90,000.

Combined Cost of HCBS and Home Health Care Needs to Be Reviewed

We believe that the main reason the cost containment limits have been set so high is that the Department of Health Care Policy and Financing has overlooked the total cost of community care for clients receiving both HCBS (unskilled) and home health (skilled) services.

Home health services are not considered when determining the cost of serving someone in the community. The cost containment limit is based on the average annual nursing facility rates (as opposed to the actual cost of nursing facility care) and is not reduced to adjust for the additional services provided by a nursing facility. In other words, the Department of Health Care Policy and Financing did not take into account that the average individual is not in a nursing facility for 365 days, and a portion of the nursing facility rates are to cover the costs of skilled care, medical supplies, or room and board (which would not be provided under the HCBS program). As a result, clients can get a level of unskilled care in the community that is much higher than the level of unskilled care that would otherwise be provided in a nursing facility.

Additionally, home health services that individuals are receiving are not considered when determining whether a person meets the criteria of costing less to serve in the community than they would to serve in a nursing facility. When a case manager assesses an HCBS client to determine whether they can be served within their cost containment limits, the home health services the client will need are not taken into consideration. As a result, the Department of Health Care Policy and Financing does not get a complete picture of the costs of serving individuals in the community as opposed to in a nursing home. For example, about 25 percent of HCBS-EBD participants, statewide, also received home health (skilled) services. As mentioned earlier, we estimated that the State spent more than $14.5 million, or an average of $22,000 per person, beyond what services in a nursing home may have cost, by serving some of these individuals in the community.

According to a 1996 report issued by the American Association of Retired Persons (AARP), without looking at both the unskilled and skilled services a person is getting, the comparison between supporting a person in the community and supporting a person in a nursing facility is distorted.

Elevated Service Limits Increase Pressure on Program Budgets

Nationally, both skilled and unskilled Medicaid services are recognized as an area where overutilization, fraud, and abuse may occur. Having realistic caps on payments is critical in a fee-for-service payment environment. While Colorado has not yet had to limit the number of eligibles served, at some point in the future, rising costs, combined with an increasing number of eligible individuals, will create budgetary pressure. Home health and HCBS services will be limited by the amount of state general funds available. In addition, having a realistic cap is important for case managers in setting appropriate boundaries on unskilled care. Because the Department has not set appropriate limits for unskilled care, it may be paying for individuals to be served in community settings when, likely, it would be more cost-effective to serve these individuals in a nursing facility. In addition, not setting reasonable limits on skilled care can result in more services being paid for than are needed and more opportunity for abusive billing practices.

Colorado Has Options for Realistically Limiting HCBS and Home Health Services

The federal government has given states virtually unlimited authority for establishing cost containment controls in their Medicaid programs. As a result, Colorado has many options for how to manage the cost of both skilled and unskilled care. Providing services to the greatest number of people in the most cost-effective way should be the overriding goal of the program. Department of Health Care Policy and Financing staff believe it is an achievable goal to have a combined limit on HCBS and home health services that ensures the total cost of community care is reasonable in comparison to the cost of nursing facility care. However, the Department is concerned that using the average cost of nursing facility care ($25,530 for Fiscal Year 2000) may set the limit for combined services too low. Choosing how to set the limits and at what dollar amount is an important policy decision. As a result, the Department should work with the General Assembly to clarify the language regarding the upper payment limits on both skilled and unskilled care. Some of the options could include:

- **Establishing fixed limits in law.** For HCBS or home health services these caps could be one fixed amount. These limits could be increased annually by the Consumer Pricing Index (CPI). In addition, statute should define the circumstances, if any, for which an individual will be allowed to exceed such limits.

- **Establishing limits based on level of need.** For HCBS or home health services various categories of need could be established in law. Some examples could include low, moderate, high, and hospital level of care. For each level there would be a corresponding limit set on the dollar amount of services that could be provided. Establishing limits or caps based on level of care requires that the Department of Health Care Policy and Financing utilize a reliable assessment tool and set up an appropriate structure for limits that corresponds to the assessed level of care. If the Department of Health Care Policy and Financing and General Assembly choose this option, the Department of Health Care Policy and Financing should evaluate the adequacy of its current assessment tools for accomplishing these tasks. Again, statute should define the circumstances, if any, for which an individual will be allowed to exceed such limits.

- **Taking a managed care approach for funding HCBS and home health services.** This approach could include paying providers, or another gatekeeping agency, a set dollar amount for providing all necessary services to all eligible individuals needing services.

Systems for Monitoring Costs Need to Be Improved

In addition to the problems with the cost containment limits for HCBS (unskilled) and home health (skilled) services, we found that the Department does little to monitor the overall costs of an individual's care. Although the Department completed a focused study on community long-term care in November 2000 evaluating costs in the HCBS and Home Health programs, this study did not evaluate the total cost of serving individuals in the community who get both home health and HCBS services. Further, the Department needs to improve its analysis of claims data on an ongoing basis and better coordinate with the SEPs in terms of cost control. We used an inexpensive audit software program to analyze over 420,000 claims. Whether the Department needs a new software program or whether its current software capabilities are adequate, the Department should develop the capability to routinely analyze the data. Developing in-house analytical capability is essential for sound financial management.

Recommendation No. 51:

The Department of Health Care Policy and Financing should work with the General Assembly to develop more appropriate service limits for HCBS and home health services.

Department of Health Care Policy and Financing Response:

Agree. The Department will work with the General Assembly to develop more appropriate service limits for HCBS and home health services. The Department will take immediate action to ensure that the HCBS program complies with all state and federal requirements.

In addition, the Department will screen the caseload, by October 1, 2001. Clients with extraordinary medical needs may need to be served through a separately authorized program. The Department will recommend a legislative solution for such clients if the caseload analysis justifies it.

Recommendation No. 52:

The Department of Health Care Policy and Financing should establish procedures for routinely monitoring the overall costs of skilled and unskilled care for individuals in community settings.

Department of Health Care Policy and Financing Response:

Agree. The Department will establish policies for routine monitoring of the costs for individuals by October 1, 2001, and propose any required regulations to the Board of Medical Services at its November 2001 meeting.

Payment Controls Should Be Improved

During our review of home health (skilled) and HCBS (unskilled) claims we found several instances where controls over provider payments were lacking and where postpayment review to identify inappropriate payments was insufficient. The Department of Health Care Policy and Financing has two primary defense mechanisms for preventing inappropriate payments for its Medicaid programs.

- **Automatedsystem edits**. The State contracts with Consultec (the State's Fiscal Agent) for processing all Medicaid claims. Consultec and the Department of Health Care Policy and Financing work together to maintain a payment system that

employs automated edits and controls to help ensure that the Medicaid payments made are allowable. This system is called the Medicaid Management Information System (MMIS), and is the Department of Health Care Policy and Financing's primary control over ensuring that payments made are allowable, paid at the correct rate for the service type, not duplicative, and only for Medicaid-eligible clients.

- HCBS (unskilled) services are specifically controlled by the MMIS system through automated edits that do not allow payment for any services other than those that have been prior authorized by the Single Entry Point (SEP) agencies on the client's PAR (Prior Authorization Request).

- Home health (skilled) service authorization and utilization are currently controlled only through postpayment review. However, under the new home health rules, home health services will also be controlled via a PAR document, and the MMIS system will not pay for home health services that are not prior authorized.

- **Postpayment review**. The Department of Health Care Policy and Financing also has a Program Integrity Unit (a unit within the Department's Quality Assurance Section) that works on postpayment review and claims review for Medicaid claims to identify instances of inappropriately paid claims and to recover those payments. This unit currently has 5 FTE (one of which is vacant) dedicated to the review of about 12.5 million Medicaid claims paid for all Medicaid programs. To supplement the activities of this unit, the Department of Health Care Policy and Financing contracts with outside providers to conduct claims reviews. Additionally, the Department is in the process of trying to implement contingency-based contracting for post-payment review of claims. Contingency-based contracts would allow an outside contracting agency to investigate claims, recover on inappropriately paid claims, and keep a portion of the recoveries.

Existing Rules Do Not Ensure That Services Paid For Are Authorized or Medically Necessary

Currently home health services are authorized on the home health certification or plan of care (the HCFA 485 form). Essentially, the plan of care states the type of services to be provided and the number of visits per day, week, or month. This plan of care is revised every two months. According to staff at the SEPs, the home health agency will write up the plan of care and a physician signs the plan. Under the current rules for home health billing, claims for services will be paid as long as the service billed is allowable, the client

is Medicaid-eligible, and the provider submits a physician's referral number on the claim. Other than these items, there are no edits in the system that prevent home health agencies from billing for unauthorized or unnecessary services. The only manner in which HCPF will find that unauthorized services are being billed is through postpayment claims and case file review. With over 160,000 home health claims processed in Fiscal Year 2000, it would be difficult for HCPF's Program Integrity Unit to perform postpayment review on a large enough volume of claims to obtain assurance that services paid for are authorized and medically necessary. During our audit we found several examples of payments for home health services that appeared to be unauthorized or not medically necessary. According to Program Integrity Unit staff, the reviews they have completed have resulted in similar findings.

- **Services paid for were not included on plans of care.** During our audit we reviewed home health plans for 20 clients in our case file sample and compared what was authorized on the plan of care with what was actually paid for during the same time period. For 9 of the 20 (45 percent) clients reviewed, we found services paid for that were not authorized. In total, we found about $25,000 in unauthorized services provided during the six-month period from approximately January 1, 2000, to June 30, 2000.

- **Home health plans of care were not signed by the physician.** During our review of home health plans for 20 clients, we found that the home health plans of care were not signed by the physician in 40 percent of the cases. As a result, it is questionable whether a physician actually authorized all services provided and paid for these clients. In total, these clients received over $280,000 in home health services that could potentially be denied due to lack of documentation.

- **Home health and HCBS services are sometimes duplicative.** Our case file review identified instances of personal care services being included in both the HCBS and home health plans of care. Further, we found instances where both the home health care provider and HCBS provider were billing for personal care services on the same day for the same client. In some cases the services listed as provided in the provider logs appeared to be duplicative. As an example, the HCBS personal care provider comes in two times a day to clean the bathroom and comb and set the client's hair. A home health provider was also billing for these same services on the same days, within a short time after the HCBS provider was at the client's home. In some cases it was not apparent that services were needed from both types of providers. In a review of provider documentation of services provided, we identified a total of about $2,000 in services that were paid for and appear to be duplicative. In most cases the duplicative services were provided by the same service provider agency.

- **Some services provided appeared to be unnecessary.** Our review of home health plans and claims data identified one instance of physical therapy services being provided to a 94-year-old woman who was wheelchair-bound. According to a registered nurse at the SEP who is familiar with this client's medical history and reviewed the client's home health plan of care, this client should not be getting physical therapy, because she is not benefitting from the therapy. This client received almost $5,200 in physical therapy services during Fiscal Year 2000. In our review we found that therapy services should typically be limited, and services should be discontinued when the therapist can no longer show that the person is benefitting from the therapy. In addition, many physical therapy techniques can be taught to the client or the client's caregiver and continued without continuous visits by the therapist. Closer attention should be paid to the authorization and use of therapy services to ensure that services provided are medically necessary and beneficial to the client.

The claims identified in the above examples are potentially recoverable items that the Department will have to investigate further.

New Home Health Rules Are a Step Toward Accountability

Since 1999 the Department of Health Care Policy and Financing has worked with the Medical Services Board, the SEPs, service providers, and client advocacy groups at revising the current system of authorization for long-term home health care provided by the Medicaid Home Health program. The Medical Services Board recently passed the new home health rules, and implementation is planned for July 1, 2001. The Department has worked to implement these rules because it recognizes that the existing rules for home health allow many loopholes for payment of services that are not authorized and for duplication of services between the HCBS and Home Health programs. The Department has completed a series of four studies on the growth and expenditures in the Home Health program. The new home health rules are one of the additional controls in place that the Department hopes will reduce the occurrence of inappropriate billing and service practices.

Under the new home health rules, all home health services will be controlled through Prior Authorization Request (PAR) documents similar to those used in the HCBS system. HCBS claims will only be paid if the claim submitted is for services authorized on the PAR document. For clients getting both HCBS and home health services, the SEPs will be responsible for reviewing and approving the PAR documents. PARs for all other home health participants will be reviewed and approved by the State's Fiscal Agent, Consultec. The Department hopes that these rules will reduce the occurrence of unauthorized service

payments, that there will be less duplication between HCBS and home health services, and that unnecessary services will be prevented.

Recommendation No. 53:

The Department of Health Care Policy and Financing should monitor the implementation of the home health rules. Specifically, the Department should evaluate the effectiveness of the new rules in preventing payment for services that are not authorized, preventing duplication between HCBS and home health services, and preventing services that are not medically necessary from being provided.

Department of Health Care Policy and Financing Response:

Agree. The Department will monitor the implementation of the new home health rules and their effectiveness in preventing payment of unnecessary services. The Department is currently training SEPs on their new responsibilities for prior authorization of HCBS and home health services and will monitor the SEPs directly and through the Department of Human Services. Rules will be modified or added as needed. The Department will use contingency-based contract vendors to ensure that providers are complying with the rules.

In addition to the new SEP responsibilities, the Department implemented several other changes to the HCBS and Home Health programs which have significantly reduced the cost increases in both of these programs. The changes include growth caps, measurement guidelines for the use and length of time to complete certain tasks in the home, new edits in the MMIS, payment units based on time instead of visits, and limitations on nurse assessments.

Postpayment Review Processes Should Be Improved

The Department of Health Care Policy and Financing employs 5 FTE in its Program Integrity Unit. The primary mission of this unit is to identify instances of inappropriate payments and recover payments when necessary. Our audit revealed several problems with the manner in which this unit handles the review of Medicaid claims related to the HCBS-EBD and Home Health programs. Specifically, we found:

Follow-Up on Problems Identified Is Not Always Done

The Department paid about $140,000 to the Colorado Foundation for Medical Care (CFMC) to perform a review of HCBS-EBD and home health claims. The results of this review were reported to the Department in April of 2000. CFMC reviewed a large sampling of claims for both programs and found very high occurrences of inappropriately billed services. In total, CFMC found that 22 percent of the total dollar value of HCBS claims sampled were billed inappropriately and were likely recoverable. In addition, 37 percent of the total dollar value of home health claims sampled were also found to have been billed inappropriately and to likely be recoverable. The total dollar amount identified as recoverable for these HCBS and home health claims combined was over $23,000. These findings are significant. In the same study, CFMC recommended that the Department conduct several focus studies to further identify inappropriate billing practices. However, more than one year has passed since these recommendations were made, and the Department has still not done any of the additional studies or recovered on the inappropriate payments identified by CFMC.

Our audit also performed a claims review and found problems similar to those in the CFMC study, including about $5,000 (10 percent of the total dollars reviewed) of services for 18 clients that were inappropriately charged for reasons including that the service was not documented, the services were duplicative of other services that the client was receiving, the service appeared unnecessary, or the provider was unbundling the services (e.g., billing both the home health and HCBS programs for the same care for one client).

Volume of Claims Review Is Not Adequate to Provide Assurance That Claims and Expenditures Are Appropriate

Of the total 5 FTE in the Program Integrity Unit, only 1 FTE is dedicated to the review of about 1,200 home health and HCBS service providers (including providers not certified by the Health Facilities Division). According to documentation provided by the Program Integrity Unit staff, they reviewed a sample of claims for about 100 HCBS and home health providers paid during Fiscal Year 2000. The provider reviews resulted in a little over $110,000 in recoveries for Fiscal Year 2000. For Fiscal Year 2001 (through April) the Program Integrity Unit has recovered about $102,000. The largest recovery year was in Fiscal Year 1999 when nearly $485,000 was recovered. The Program Integrity Unit could not identify the total number of claims reviewed for the providers in their sample. The volume of review conducted is insufficient and does not provide adequate oversight of HCBS and home health expenditures. Similar findings were reported in our 1999 audit of Medicaid Fraud and Abuse, in which HCPF agreed to increase the volume of postpayment review of home health providers.

Aggregate Data Review Is Not Used to Identify Potential Problem Areas

According to interviews with Department staff, aggregate claims data are used for identifying outliers and selecting providers and claims for postpayment review. However, the Department is not doing some of the more basic types of aggregate data review, such as reviewing claims paid by service type, reviewing claims paid to ensure that providers are not paid for services that they are not certified to provide, or doing ongoing review of claims to ensure that payments are not made for services after the client's date of death. During our review we performed several tests of aggregate data using an audit software with the capability to handle large volumes of data. Some of the problems we identified are discussed in subsequent sections of this report and include payments made for unallowable service types, payments made to uncertified providers, and payments made for service dates after the date of the client's death. Each of these findings resulted from an aggregate test of the data, such as looking at the data by service type, or matching dates of death or lists of certified service providers to the claims data. These types of aggregate data analysis could provide HCPF with important trend information on the types of services being provided, amounts paid to specific providers, or amounts paid on behalf of clients, and this information could indicate problems with provider billing practices, or provider abuse. Such analysis would allow for a more effective postpayment review that targets unusual payments and identifies system edits that are not functioning properly.

Postpayment review is the last defense the Department can employ for preventing fraudulent and abusive billing practices for Medicaid programs. With the volume of claims the Department is responsible for, sampling is obviously a tool that must be used in order for the staff to provide the best coverage with the fewest resources. However, the amount and type of reviews that are ongoing are inadequate to ensure that the Department is meeting its fiscal responsibilities for these programs.

There are aggregate data reviews that are also critical. HCPF should be reviewing total claims expenditures by type of service and by provider on a quarterly basis to identify trends and potential areas of abuse. Likewise, it could easily automate certain reviews that could be done periodically to match data sets from death records or certified provider lists to identify claims that were potentially paid inappropriately. These types of review are not time- or staff-intensive but could provide HCPF with better coverage of their claims data, as well as better information from which to choose samples of claims or providers to review. According to Department staff, they already have the software capabilities to do these types of analyses.

Recommendation No. 54:

The Department of Health Care Policy and Financing needs to increase the value added by its Program Integrity Unit by doing the following:

a. Increasing the volume of reviews performed on claims data, and scheduling certain types of reviews to occur in an ongoing way.

b. Changing the Department's review methodology from a strictly sampling methodology to one that also incorporates aggregate data analysis and review.

c. Utilizing the information provided through other agency reviews of claims to implement prevention measures and recover additional monies paid out incorrectly.

Department of Health Care Policy and Financing Response:

Agree. The Department stated, in its response to the July 1999, State Auditor's Recommendation on extending oversight of home health agencies with post-payment review, that it could only expand such review by receiving additional resources or using "contingency-based contracting." This authorization was requested in the Department's November 1, 1999 report to the JBC, which was authorized on June 22, 2000. Since that time, the Department has promulgated RFPs for three of the five projects, and has awarded contracts for two of the five contracts. In addition, the Department requested additional FTEs for the Program Integrity Unit (PIU) in its Budget Request for Fiscal Year 2002. In maximizing these new resources, the Department agrees to incorporate the Auditor's recommendations.

In the past, to maximize the Department's limited resources, the PIU conducted focused studies in home-based services by reviewing a small sample of clients per provider in an effort to address rising costs in home health care. The Department believes that, in order to create a sentinel effect and inform providers of the requirements, it is more important to review a larger number of providers versus a larger number of clients from only a few providers. The Department believes that these recommendations can be fully implemented by July 1, 2002, using the contingency-based contractor.

Additional Payment Controls Are Needed

During our review of claims data for Fiscal Year 2000 HCBS and home health payments, we found several instances in which additional system edits or controls in the MMIS system would have prevented inappropriate payments to providers. Our review identified several weaknesses in payment controls.

MMIS Allows Payment to Uncertified Providers

Each provider of HCBS (unskilled) and home health (skilled) services must be certified as a Medicaid provider to receive Medicaid payments. For HCBS, service providers must be certified separately for each different service type they would like to provide. For example, one provider may offer personal care services and adult day care services. This provider must be certified as both an adult day care provider and a personal care provider. The MMIS system does not currently have an edit in place that allows providers to be paid only for services that they are certified to provide. According to staff at Consultec, when originally setting up some of the system edits, installing an edit that would prevent payments for services to providers that are not certified for that payment type was discussed. However, the Department never pursued the edit. In June 2000 the Department added several edits to the MMIS system to prevent payments to uncertified providers from occurring in the Home Health program; however, these same edits are not in place for the HCBS program.

For Fiscal Year 2000 we found about $15,000 in services paid to four providers who were not certified to provide the services for which they were paid. In Fiscal Year 1999 we paid an additional $43,000 to one of these same providers for services that the provider was not certified to provide. According to Department staff, the Department does not periodically check to see whether providers are providing services for which they are not certified. The Department should be able to automate this check and integrate it into its claims review process.

MMIS Does Not Prevent Inappropriate Use of Acute Home Health Revenue Codes

Under the current (and future) home health rules, home health agencies are allowed to provide acute home health care, without prior authorization. Acute home health is provided to a client when they have an immediate need for a service due to a sudden sickness or injury. Acute home health is not meant to be continued over the long term. Ongoing home health services are billed to long-term home health revenue codes. Because acute home health does not have to be authorized prior to the service's being delivered,

these services do not have to appear on the client's plan of care and, as a result, are a higher risk for abuse and inappropriate billing. Although the Department did recently add an edit to the MMIS system to prevent providers from being able to bill for services in excess of the daily dollar limits, these edits do not ensure that acute home health codes are used appropriately. Currently the only method used by HCPF to identify instances of acute home health codes being used inappropriately is postpayment review. During our review of home health plans for a sample of 20 clients, we identified 3 clients who had plans of care in place but for whom all services paid during the six-month period reviewed were charged to acute home health codes. A system edit to identify frequent or ongoing billing of acute home health for one client may help to focus reviews and identify instances of provider abuse. This will be even more critical under the new home health rules where long-term home health services will be much more tightly controlled and acute services will not.

MMIS Continued to Allow Payments for Services After the Client's Death

During our review of Fiscal Year 2000 claims data, we performed a data match to identify payments for services that may have occurred after the client's date of death. For this review we obtained the dates of death for 201 clients served by the five SEPs in our sample areas who died between July 1, 2000, and October 31, 2000. We matched these clients to a database of nearly 95,000 claims for HCBS and 51,000 home health claims with service dates occurring during the same time period. Although we did not find any home health claims paid inappropriately, our review identified about $3,000 in HCBS claims paid on behalf of five clients (2 percent of all clients sampled) for services after their dates of death. The majority of these costs were for personal care services for one client. Of particular concern is that we found these problems in a small sample of clients and also in a small sample of claims. This could indicate that a much larger dollar amount of claims is being paid for clients who are deceased. A 1999 audit of Medicaid Fraud and Abuse identified problems with the dates of death being entered into the MMIS system in a timely fashion. If the date of death is entered into the system after claims have already been paid for services occurring after that date, the system does not go back and recover those claims. The Department of Health Care Policy and Financing agreed to implement the 1999 audit recommendations.

Edits for Some Unallowed Service Types Are Missing

A review of all skilled care claims paid during Fiscal Year 2000 identified four types of services paid for that are not covered benefits of the Home Health program. In total, MMIS paid claims amounting to about $5,200 for services that the Home Health program does not cover. For these services, Consultec was unaware that the particular service was not a covered benefit of the Home Health program, and therefore, no edit had been set up to prevent payment for these service types. The Department is responsible for notifying Consultec of the edits that should be in place. It is critical that the MMIS system is updated frequently and that the Department reviews edits and expenditures to ensure that the State and Medicaid are not paying for services that are not covered. According to HCPF staff, the Department does not currently review all expenditures by program to ensure that unallowable types of expenditures have not been made. This review is neither time- nor staff-intensive and prevents payment for inappropriate types of services. Further, these types of problems should be easily prevented through automated edits.

Staff at Consultec Overrode Edits and Paid Claims for Unallowable Services Under Home Health

Our review of all home health payments identified three types of services, totaling about $4,300, that are not covered benefits of the program. According to staff at Consultec, these claims were paid because of clerical mistakes; specifically, staff had overridden edits. According to Consultec staff, these errors should not have been made. There are few reasons, if any, to override edits and pay claims for services that are not covered. HCPF should ensure that appropriate levels of supervision are in place for reviewing and approving instances where edits are overridden. One concern is that with the volume of staff turnover at Consultec, training needs to be provided more frequently on the appropriate circumstances for overriding edits.

Decreases to PAR Services Are Not Entered Into MMIS

The MMIS system will only process payments for services that are authorized on the client's PAR document. If a provider bills for a service not included on the PAR, the system will deny payment. Currently decreases to PAR services are not required to be submitted to Consultec for entry into the MMIS system. As a result, if a case manager decreases the amount of services that a client is supposed to receive, that decrease will not be reflected in the MMIS system and a provider could continue to bill for services that are no longer authorized. Decreases to PAR services should be a required entry into the MMIS system.

Additional Controls Are Needed Over Home Modification Services

Once a PAR has been entered into the MMIS system authorizing a home modification (a service offered through the HCBS program), the provider could theoretically bill and be paid for the entire project prior to ever completing any of the work. There are no controls in place in the MMIS system that prevent a contractors from being paid until the work is completed satisfactorily or, if the project is large enough, until it has been formally inspected. As an example, one of the clients in our case file review was authorized about $4,000 for a bathroom remodel job. The initial contractor completed some of the work but left prior to finishing the job. As a result, the HCBS program paid about $16,000 for a new contractor to come in and redo the job correctly. The Department has since recovered nearly $5,400 from this provider. Department staff acknowledge that this is a problem; however, they also stated that the same problem is true for all HCBS service types. Theoretically, a provider could bill for all services authorized on the PAR at one time prior to providing the services. This, however, is not allowed by the rules for how providers are to bill for services.

Automated edits in a payment system are the State's best defense against inappropriate payments to service providers, for all Medicaid programs. The types of problems identified during this audit are preventable through the use of system edits.

Recommendation No. 55:

The Department of Health Care Policy and Financing should work with Consultec, the State's Fiscal Agent, to implement additional system edits and controls to address the types of issues identified during this audit, increase oversight of edit resolutions, and increase monitoring of Consultec`s training of staff. Further, the Department should perform ongoing review of the edits in place to ensure that edits are set and functioning correctly and to identify areas for improvement.

Department of Health Care Policy and Financing Response:

Agree. The Department has addressed many of the issues identified in the audit and will continue to do so. Edits are already in place to prevent payment for non-benefits and to place a daily payment limit on acute home health services. Beginning July 1, 2001, prior authorizations will be required for long-term home health services. The Department will continue to investigate ways of improving

edits over home health and HCBS. The Department has also conducted an investigation and produced a report on improving date of death information.

All edits have resolution text that instructs the individual handling the claim how to process the specific claim posting this edit. The Department and the fiscal agent have regular, weekly meetings. The fiscal agent operations staff and the State's business analysts have been utilizing these weekly meetings to address edits in a critical priority order. A schedule has been developed with completion defined in July 2001. The Department will require the fiscal agent to provide enhanced training and monitor staff for appropriate implementation of the edits by August 2001.

Assessment and Eligibility Processes Should Be Improved

Currently the eligibility determination process for HCBS services is a two-step approach. The first step is for the applicant to apply for services at the Single Entry Point (SEP) agency in their area. The SEP then conducts the initial functional assessment and prepares an initial plan of care for the client. The SEP then forwards the assessment to the Colorado Foundation for Medical Care (CFMC). CFMC is the agency that the Department contracts with as its Peer Review Organization (PRO) and utilization review contractor. The Department has delegated final eligibility determination authority to CFMC for the HCBS programs.

The client assessment process is currently separate from the eligibility determination process. The SEP agencies assess the client's functionality using standards established in the ULTC-100 assessment document. SEP staff meet with the client in person, in the client's home, and verify all information related to assessment criteria. SEP staff do not determine whether the client is actually eligible. The ULTC-100 is forwarded to CFMC for final eligibility determination. Upon receipt of the ULTC-100, CFMC either data enters and automatically approves the client for services, or does a desk review of the ULTC-100 and then approves or denies eligibility. During our audit we found that eligibility determination could be streamlined. Restructuring the assessment and eligibility processes will result not only in cost savings but also in a more effective screening process.

In our sample of 138 client records, we identified 14 clients who should not have been approved for services. The five SEPs we visited identified an additional 12 clients, not included in our sample, who they believe should not have been approved for services by CFMC. In all 26 cases the clients were either highly functional or the physician's referral

specifically stated that the client did not need long-term care. During Fiscal Year 2000 these clients received nearly $109,000 in HCBS services and an additional $164,000 in other Medicaid State Plan benefits. We believe that the high rate of inappropriate approvals and resulting costs is related to the fragmentation of the assessment and eligibility determination processes.

Separating the processes of assessment and eligibility determination also results in higher administrative costs. During Fiscal Year 2000 the Department paid SEPs about $2.6 million (about one-fifth of total SEP payments) for client assessments and CFMC nearly $500,000 for determining eligibility. CFMC's review of the ULTC-100 does not add any new information to the assessments performed by the SEPs. As a result, the additional step of having CFMC determine eligibility either through data entering or doing a desk review of the paperwork already prepared by the SEPs is unnecessary. In addition to being costly, a two-step approach for eligibility determination increases the time a client will have to wait to receive services. We believe that the functions of assessment and eligibility determination could easily be combined for a more cost-effective and time-efficient system. The Department is currently in the process of exploring other options for moving several of CFMC's current duties to the SEPs, including allowing SEPs the authority to make eligibility determinations.

Recommendation No. 56:

The Department of Health Care Policy and Financing should evaluate the costs and benefits of combining assessment and eligibility determination, and establishing an independent third-party review of these processes.

Department of Health Care Policy and Financing Response:

Agree. The Department is in the middle of a large redesign implementation that will combine the SEP assessments with SEP determinations of admission or denial to long-term care programs. CFMC will stop work on eligibility determination in March of 2002. The Department anticipates hiring a balance of state contractor to provide oversight of the process, to monitor consistency with SEPs, and to conduct long-term care reviews that SEPs are unable to assume.

Oversight of the SEPs

The Home Health and HCBS programs involve a complicated web of interagency involvement. The Department of Health Care Policy and Financing is the lead agency and contracts with other agencies to oversee and provide coordination for HCBS and home health services. Specifically, the Health Facilities Division (the Division) is contracted to oversee and investigate service provider quality-of-care issues; the Department of Human Services (DHS) is contracted to review the activities of the 25 SEP agencies; and the 25 SEPs are contracted to provide assessment, service planning, and case management services to HCBS program participants. We found several instances where oversight and communication among all agencies involved should be improved.

The Department of Human Services (DHS) monitors the SEP contractors under a cooperative (interagency) agreement with the Department of Health Care Policy and Financing. DHS's oversight responsibilities include training, technical assistance, monitoring, and making recommendations to the Department of Health Care Policy and Financing regarding provider certification, and financial audits for SEP agencies. Our review concentrated on the oversight components of DHS's review including DHS's monitoring, certification, and financial audits of the SEP agencies. We found room for improvement in several areas.

Financial Compliance Reviews

DHS is responsible for conducting on-site financial compliance reviews (FCRs) for each SEP agency. The factors determining the frequency of the FCRs are mutually agreed upon by DHS and HCPF. The review is limited to an examination of the program expenditures and the reimbursement of these costs reported by the SEP system. We identified the following problems with the FCRs:

- **Financial compliance reviews performed by DHS are not timely, consistent, or cost-effective.** The most recent Financial Compliance Reviews conducted at four out of the five SEPs we visited were five years old, conducted in Fiscal Year 1996. Another SEP had their review in Fiscal Year 1999 for the three-year period covering 1997, 1998, and 1999. Additionally, one of the largest SEPs has not had a review since 1996. In total, for the five SEPs we visited, DHS recovered about $400,000 as a result of the compliance reviews. DHS explained that they try to conduct these audits every three to four years, but only one of the five had a review in that time

frame. Since the recoveries resulting from these reviews are significant, the reviews should be conducted annually.

- **SEPs are not reverting the unspent monies without a review.** SEPs are required to revert any funds that they received but did not spend during the Fiscal Year. However, for the five SEPs in our sample area, DHS recovered about $260,000 in funds that the SEPs did not spend and that were not reverted prior to DHS's review. Although there is some confusion between HCPF and DHS staff as to whether SEPs are reverting funds when compliance reviews are not conducted, our review confirmed that the SEPs are not reverting the funds for years in which they do not receive a financial compliance review. HCPF should include penalties and lost interest in the SEP contracts that ensure SEPs comply with requirements to revert unspent funds.

With HCBS program costs increasing greatly each year, it is imperative that the oversight procedures in place concentrate their efforts on reviewing issues that directly relate to client care and cost control. As a result, we believe that the Department of Human Services should improve the oversight of the SEPs. It is possible that financial compliance reviews could be included as an agreed-upon audit procedure during the counties' annual financial audits. If this were done, DHS could review the results during its desk review of the financial audits. Recoveries from the annual compliance reviews would offset some or all of the costs of the more frequent reviews.

Recommendation No. 57:

The Department of Health Care Policy and Financing should include enforcement actions in the SEP contracts that penalize the SEP for not reverting funds in accordance with Department policy.

Department of Health Care Policy and Financing Response:

Agree. The Department will explore requiring the SEPs to, periodically during the contract year, complete and submit a credit balance report. The report will be desk reviewed by Department staff. The Department will consider penalties for not reverting unexpended funds as part of its review of its SEP payment methodology. Enhanced financial compliance reviews will be necessary to

accurately identify unexpended funds. This will be incorporated in SEP contracts for Fiscal Year 2003.

Department of Higher Education

Introduction

The Department of Higher Education includes all public higher education institutions in the State, as well as the Auraria Higher Education Center, the Colorado Commission on Higher Education, the Colorado Council on the Arts, the Colorado Student Loan Division, the Colorado Student Obligation Bond Authority, the Colorado Historical Society, and the Division of Private Occupational Schools. Please refer to page 49 in the Financial Statement Findings section for additional background information.

Board of Regents of the University of Colorado - University of Colorado

The University of Colorado was established on November 7, 1861, by an Act of the Territorial Government. Upon the admission of Colorado into the Union in 1876, the University was declared an institution of the State of Colorado, and the Board of Regents was established under the State Constitution as its governing authority.

The University consists of a central administration and four campuses: Boulder, Denver, Colorado Springs, and Health Sciences Center. These four campuses comprise 16 schools and colleges.

The following comments were prepared by the public accounting firm of KPMG LLP, who performed audit work at the University of Colorado.

Subrecipient Monitoring at the University of Colorado at Boulder Should Be Expanded

The University of Colorado receives substantial federal awards at each of its campuses. Some of these funds are passed on to other universities, local municipalities, nonprofit organizations, and private companies. Under Office of Management and Budget (OMB) Circular A-133, the University, as a pass-through entity of federal awards, is responsible for:

- Identifying to the subrecipient the federal award information and applicable compliance requirements.

- Monitoring the subrecipient's activities to provide reasonable assurance that the subrecipient administers federal awards in compliance with federal requirements.

- Ensuring required audits are performed and requiring the subrecipient to take prompt corrective action on any audit findings.

- Evaluating the impact of subrecipient activities on the pass-through entity's ability to comply with applicable federal regulations.

Factors such as the size of awards, percentage of the total program's funds awarded to subrecipients, and the complexity of the compliance requirements may influence the extent of monitoring procedures.

Monitoring activities may take various forms, such as reviewing reports submitted by the subrecipient, performing site visits to the subrecipient to review financial and programmatic records and observe operations, arranging for agreed-upon procedures engagements for certain aspects of subrecipient activities, such as eligibility determinations, reviewing the subrecipient's single audit or program-specific audit results, and evaluating audit findings and the subrecipient's corrective action plan. The University of Colorado at Boulder (UCB) utilizes receipt of single audit reports as their monitoring activity.

We noted that UCB's policy states that for subcontracts over $25,000, the pass-through entity must supply the UCB with a letter stating its compliance with OMB Circular A-133 and/or supply it with the audit report. Any reports received with findings related to the University's specific subawards or Research and Development cluster control findings must be followed up on to ensure the corrective action plan is put in place and the findings are resolved. We tested 13 subawards and noted that 2 entities had single audit reports with findings related to the Research and Development cluster. There was no documentation of the review of the OMB Circular A-133 reports to determine if the findings would impact or were related to the specific subawards the University had granted to these subcontractors.

We recommend the University ensure there is a documented review of each subrecipient audit report. This review could be a single sheet of paper or documentation of the work performed in a spreadsheet (currently in use at the University of Colorado Health Sciences Center). This documentation should be completed when each audit report is received and reviewed. The documentation should include whether the subcontractor was in compliance

with the OMB Circular A-133 requirements as well as any findings related to the University's specific subaward and/or the Research and Development Cluster. Discussions with the subcontractor or principal investigator relating to the status of findings and the corrective action plan should be included.

Recommendation No. 58:

The University of Colorado at Boulder should ensure that review of audit reports of the subrecipient monitoring activity addresses proper review and resolution, if any, of findings noted in the reports.

University of Colorado Response:

Agree. University of Colorado at Boulder's Office of Contracts and Grants will implement a process no later than December 31, 2001, to document its review of each subrecipient's audit report and resolution, if any, of findings in the reports.

State Board of Agriculture

The State Board of Agriculture has control and supervision of three distinct institutions: Colorado State University, a land-grant university; Fort Lewis College, a liberal arts college; and the University of Southern Colorado, a regional university with a polytechnic emphasis.

The Board administers the State Board of Agriculture Fund located in the State Treasury. The Board is authorized to fix tuition, pay expenses, and hire officials. The chief academic and administrative officers are the chancellor of the Colorado State University System and the president of each institution.

University of Southern Colorado

The University of Southern Colorado was incorporated in 1935. On July 1, 1975, the State Legislature granted the institution university status. Three years later, the Colorado State Board of Agriculture assumed governance of the University. The University of Southern Colorado is accredited at the bachelor's and master's levels, with special emphasis on polytechnic education.

The following comments were prepared by the public accounting firm of Clifton Gunderson LLP, who performed audit work at the University of Southern Colorado.

Federal Perkins Loan Program

Federal Perkins Loans are available to certain students meeting eligibility requirements established by the United States Department of Education. The loan program is partially funded by the U.S. Department of Education. The U.S. Department of Education requires certain procedures to be followed by all institutions accepting federal Perkins Loan Program dollars such as keeping certain documentation in individual files for each borrower. If these procedures are not followed, the University risks losing these federal funds to support student attendance.

Our audit procedures included testing 10 borrowers who went into repayment during the year, 10 borrowers who had their loans deferred or canceled, and 10 borrowers who went into default. We noted the following:

- For 1 out of 10 borrowers who went into repayment during the year, a required addendum to the promissory note was not included with the signed promissory note as required for all promissory notes made on or after August 1, 2000. The addendum reflects the provisions resulting from the 1998 Higher Education Amendments.

- For 10 out of 10 borrowers who went into repayment during the year, the University did follow required procedures to contact the borrower by letter during the nine-month grace period, but the University did not send the letters timely (first contact after 90 days, second contact after 150 days, and third contact 240 days after the grace period begins). The letters remind the borrower that they are responsible for repaying the loan, the amount of principal and interest due, and the due date and amount of the first payment.

- For 4 out of 10 borrowers who had their loans deferred or canceled, the University did not maintain adequate documentation in the student's file supporting the reason for a deferment of loan payments.

- For 1 out of 10 borrowers who went into default, overdue notices were not reaching the borrower because the borrower could not be located. Under 34 CFR 674.44, the school must take the following steps to locate the borrower if communications are returned undelivered (other than unclaimed mail): (1) review the records of all appropriate school offices, and (2) review printed or Web-based

telephone directories or check with information operators in the areas of the borrower's last known address. If these methods are unsuccessful, either school personnel or a commercial skip-trace firm must be used to locate the borrower. If school personnel are used, documented efforts must be comparable to commercial skip-tracing firms. If the school is still unable to locate the borrower after taking these steps, the school must continue to make reasonable attempts at least twice a year until the account is assigned to the U.S. Department of Education or the account is written off. The University was not consistent in following the steps above to locate a borrower in default.

Appropriate documentation should exist to demonstrate compliance with U.S. Department of Education requirements in order to ensure future participation in the federal Perkins Loan Program and to assist in future collection efforts to avoid default by borrowers.

The University currently sends exit counseling information to borrowers by mail and includes a copy of the mailed information in the student's file as verification of sending the information. Under 34 CFR 674.42(b), the University is required to conduct exit counseling with borrowers either in person, by audiovisual presentation, or by interactive electronic means shortly before the student graduates or drops below half-time enrollment. If individual interviews are not possible, group interviews are acceptable. If the borrower withdraws from school without the school's prior knowledge or fails to complete an exit counseling session, the school must provide exit counseling through either interactive electronic means or by mailing counseling material to the borrower at the borrower's last known address within 30 days after learning that the borrower has withdrawn from school or failed to complete exit counseling. Of the 20 borrowers tested for proof of exit counseling, only 2 had returned signed information back to the University as requested in the mailed packet of exit counseling information. Exit counseling conducted in a manner noted above as required would assist the University in receiving signed information back from students.

We understand the University is considering outsourcing the database administration and collection function for federal Perkins loans to a third party or upgrading the current database system. The University's current database for its federal Perkins loans is becoming obsolete and the University has had significant difficulties in maintaining the system. While we understand that there may be additional costs associated with outsourcing as opposed to upgrading the current system (which may not be available from the vendor), we believe the University is at risk of losing its federal Perkins loan funding from the U.S. Department of Education due to the issues noted above and similar issues noted in previous years. Outsourcing the database administration and collection function to a third party would assist the University in eliminating these issues.

Recommendation No. 59:

The University of Southern Colorado should:

a. Implement procedures to ensure that the required addendum to the promissory notes is provided to all students and included with the promissory note in the borrower's federal Perkins loan file.

b. Implement procedures to ensure that contact with borrowers during grace periods is performed on a timely basis.

c. Implement procedures to ensure that adequate documentation is obtained from students to support deferment of payments or canceled loans.

d. Implement procedures to ensure that contact and attempted contact with borrowers in default is performed as required by the U.S. Department of Education.

e. Strengthen efforts to conduct exit counseling with borrowers either in person, by audiovisual presentation, or by interactive electronic means shortly before the student graduates or drops below half-time enrollment as required by the U.S. Department of Education.

f. Ensure that individuals responsible for due diligence related to the federal Perkins Loan Program are properly trained and maintain current knowledge of U.S. Department of Education requirements.

g. Consider outsourcing the database administration and collection function for federal Perkins loans to a third party.

University of Southern Colorado Response:

Agree. The University understands the importance of complying with the federal regulations that support the federal Perkins Loan Program. Significant improvements in the management of the federal Perkins Loan Program were made during the 2001 fiscal year, and further improvements are planned:

a. The required addendum is now being included with all promissory notes.

b, c, d, f. To be addressed via staff training for those individuals currently responsible for Perkins Loans Program management and outsourcing loan collection activities.

e. A process to comply with exit counseling requirements will be developed.

g. The University is currently negotiating a contract for loan servicing of our federal Perkins Loan Program and hopes to have this process completed by January of 2002.

Return of Title IV Funds

When a recipient of Title IV grant or loan assistance withdraws from school during a payment period or period of enrollment in which the recipient began attendance, the institution must determine the amount of Title IV aid earned by the student as of the student's withdrawal date. If the total amount of Title IV assistance earned by the student is less than the amount that was disbursed to the student as of the date of the school's determination that the student withdrew, the difference must be returned to the Title IV programs as specified by the U.S. Department of Education and no additional disbursements may be made to the student for the payment period or period of enrollment. If the amount the student earned is greater than the amount disbursed, the difference between the amounts must be treated as a post-withdrawal disbursement.

Our audit procedures included testing 10 students who withdrew from school during the year and did not receive a return of Title IV funds (to test if they should have received a return of Title IV funds and did not) and 10 students who withdrew from school during the year and did receive a return of Title IV funds (to test if the return of Title IV funds was calculated and administered as required). We noted the following:

- For 1 out of 10 students who withdrew from school during the year and did not receive a return of Title IV funds, a return of Title IV funds should have been calculated because the student's withdrawal date was prior to the cutoff for making returns of Title IV funds. The calculated return of Title IV funds related to the student should have been $1,527 and was completed subsequent to year-end.

- For 2 out of 10 students who withdrew from school during the year and did receive a return of Title IV funds, the amount of return of Title IV funds was calculated incorrectly due to having used the wrong withdrawal date in the

calculation. The calculated return of Title IV funds for the two students should have been reduced by $35.

- For 1 out of 10 students who withdrew from school during the year and did receive a return of Title IV funds, the amount of return of Title IV funds was calculated incorrectly due to the wrong amount of tuition charged to the student that was used in the calculation. The calculated return of Title IV funds for the student should have been increased by $197.

- For 1 out of 10 students who withdrew from school during the year and did receive a return of Title IV funds, the University calculated the return properly but did not return Title IV monies for Federal Family Education Loans to the lender. The amount of Title IV funds not returned on behalf of the student was $1,428.

The net known questioned costs for the items noted above is $3,117.

Recommendation No. 60:

The University of Southern Colorado should implement procedures to ensure that returns of Title IV funds are calculated for all applicable students, calculated accurately, and returned to Title IV programs on a timely basis as required. The University should consider having a staff person familiar with returns of Title IV funds review the calculations made by other staff.

University of Southern Colorado Response:

Agree. While the University currently has a process that addresses the return of Title IV funds, we recognize the need to strengthen this process. USC will incorporate both technology (automated withdrawal reports) and processing (in-person calculation at the time of withdrawal) changes to strengthen our Title IV fund management. With regard to the questioned costs, USC has taken the steps to correct all student loans and has returned the $3,117.

Trustees of the University of Northern Colorado

The Board of Trustees is the governing body of the University of Northern Colorado and is composed of seven members appointed by the Governor, with consent of the Senate, for four-year terms (effective for terms beginning July 1, 1987); one faculty member elected by the faculty; and one student member elected by the student body.

University of Northern Colorado

The University of Northern Colorado was established as a teachers college, with an official creation date of April 1, 1889. Throughout the years the school underwent many name changes, but the Act changing the name to the University of Northern Colorado became law May 1, 1970, thus making official the university-level work which it has offered since 1929. The University seeks to provide all students with a broad general education as well as preparation for selected professions.

The following comment was prepared by the public accounting firm of Anderson & Whitney, PC, who performed audit work at the University of Northern Colorado.

Change Perkins Loan Grace Period

The University has $9,328,710 in outstanding Perkins loans to approximately 5,700 current and former students.

During review of the federal Perkins Loan Program (CFDA 84.038), we tested the calculation of the grace period for borrowers that withdrew from the University. The Perkins loan program allows a nine-month grace period before interest begins to accrue and repayment begins on the loan. Approximately 50 borrowers withdrew or dropped to less than half-time status during the year.

According to federal regulations, the grace period should begin the day following withdrawal from the University or the student having less than half-time enrollment. During testing we found that the grace period for students who withdrew or dropped to less than half-time enrollment did not begin until the month following the end of the semester. This allowed students who withdrew additional time before interest accrued and repayment began. Thus, the University realized slightly less interest income and had slightly less in the Perkins Loan Fund for future loans.

Recommendation No. 61:

The University of Northern Colorado should change the beginning of the grace period for Perkins loan borrowers who withdraw from the University or drop to less than half-time enrollment.

University of Northern Colorado Response:

Agree. The University is in the process of modifying the grace period algorithms in the student loan system. (Implemented, October 2001).

Trustees of the Colorado School of Mines

The Board of Trustees is the governing body of the Colorado School of Mines and is composed of seven members appointed by the Governor, with consent of the Senate, for four-year terms, and one nonvoting student member elected by the student body.

Colorado School of Mines

The Colorado School of Mines was founded on February 9, 1874. The primary emphasis of the Colorado School of Mines is engineering, science education, and research. The authority under which the School operates is Article 40 of Title 23, C.R.S.

The following comments were prepared by the public accounting firm of BKD, LLP, who performed audit work at the Colorado School of Mines.

Receipt and Use of Federal Funds

The Colorado School of Mines participates in numerous federal grant programs throughout the year. These grants are largely for research and development programs within the University and for student financial aid. Research and development and student financial aid were tested as major programs under the OMB Circular A-133 for the year ended June 30, 2001. During the year, the University had expenditures under these federal grants of $16.1 million. Our testing noted instances of noncompliance with the requirements of federal grants or OMB Circular A-133.

Improve Subrecipient Monitoring

In the fiscal year ending June 30, 2001, the University reported on its Schedule of Federal Assistance funds of $2,215,030 passed through to subrecipients in eight programs.

The requirements set forth in the OMB Circular A-133 provide that pass-through entities (in this case the University) obtain reasonable assurance that federal award information and compliance requirements are identified to subrecipients, subrecipient activities are monitored, subrecipient audit findings are resolved, and the impact of any subrecipient noncompliance on the pass-through entity is evaluated. Also, the pass-through entity should perform procedures to provide reasonable assurance that the subrecipient obtains required audits and takes appropriate corrective action on audit findings. During our testing of research and development grants, we found that the University did not adequately document information about its subrecipient monitoring. This issue was also noted in the prior year audit.

The University designates a principal investigator, usually a university professor. This investigator is responsible for approving all expenditures submitted by subrecipients and for supervision of the subrecipient. While proper supervision may be occurring, the University did not have documentation to support the monitoring process. Without the documentation, it is not possible to determine if all federal requirements had been met.

The University should maintain a database that lists all subrecipients. The database should document that the subrecipients have received an OMB Circular A-133 audit and are aware of the guidelines of this regulation. University personnel should then document their review of the audit and respond to any reported findings and questioned costs. If the University does not receive an OMB Circular A-133 audit from the subrecipient, a certification letter should be sent to the subrecipient. The subtitles on the certification letter should include the following: (1) audit not complete, (2) audit complete/no findings, (3) audit complete/related findings, or (4) not subject to audit. The database should also track any other communication or monitoring of the subrecipient by the principal investigator. If a certification letter or OMB Circular A-133 audit is not received, the subrecipient should be considered not in compliance. If a subrecipient is not in compliance, the principal investigator should be notified. The principal investigator should inform the subrecipients that payments will be withheld until they are in compliance with the regulations.

This recommendation affects the following grants: 58-0111-0-006, 2001-35107-10052, F49620-98-1-0483, DE-FC07-00CH11021, U60/CCU816929-01, R 826651- 01-0, NCCW-0096, U60/CCU816929-02.

Recommendation No. 62:

The School of Mines should develop subrecipient monitoring documentation policies and procedures to help ensure that subrecipient files are properly maintained and provide documentation for the monitoring that has occurred.

School of Mines Response:

Agree. Within the past year the University has undertaken several steps to strengthen its subrecipient monitoring. A checklist was developed and is currently in use to help determine whether a vendor or subrecipient relationship exists with a subcontractor. If a subrecipient relationship exists, the subcontractor is requested by letter to certify whether A-133 audit findings exist and provide their responses. The University will develop and maintain a database to document our subrecipient monitoring activities. Principal investigators will also be requested to complete some form of supervision checklist to verify their monitoring of each subrecipient.

Improve Documentation of Counseling Sessions of Students Who Are First-Time Borrowers or Leave School

The University has 1,161 students who received approximately $6,432,700 in loans under the Federal Family Education Loan (FFEL) program. Under the FFEL program, the University is required to conduct counseling sessions for students who are borrowing funds for the first time and students who graduate, withdraw, or drop out of school. In our testing, 3 of the 30 students tested lacked documentation of the counseling session. This issue was also noted in the prior year audit.

Recommendation No. 63:

The School of Mines should develop policies and procedures to help ensure counseling sessions are performed and documented for students borrowing for the first time and students leaving school.

School of Mines Response:

Agree. The University altered counseling session procedures and documentation, during the past fiscal year, to incorporate both paper and electronic formats. The number of FFEL program policy exceptions was reduced by more than 70 percent. To ensure continued improvement in the performance and documentation of counseling sessions, the entire Financial Aid Office staff, including all work-study students, will receive additional training. A checklist will also be employed to make certain that appropriate information on exit counseling is provided to students who are withdrawing.

Department of Human Services

Introduction

The Department of Human Services (DHS) is solely responsible, by statute, for administering, managing, and overseeing the delivery of human services throughout the State. Please refer to page 53 in the Financial Statement Findings section for additional background information.

Implement On-Site Monitoring of County TANF Activities

In 1996 Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), established federal welfare reform requirements and created the Temporary Assistance for Needy Families (TANF) program (CFDA 93.558). In July 1997 the Department of Human Services implemented TANF in Colorado as the "Colorado Works" program.

In Fiscal Year 2001 the Department expended over $197.6 million in federal financial assistance and state general funds for the operation of the TANF program. TANF was one of the largest federal grants administered in Colorado in Fiscal Year 2001, ranking sixth overall in terms of expenditure levels. The TANF program is overseen by the Department's Office of Self-Sufficiency and administered locally by the county departments of social services. Each county is responsible for maintaining and following its own Department-approved county plan outlining TANF policies and procedures.

The Department is ultimately responsible to the U.S. Department of Health and Human Services for ensuring that the State as a whole properly administers the TANF program and meets federal requirements. Because of the level of responsibility vested with the counties, the Department must monitor county activities in order to meet its responsibilities.

The Department Did Not Complete Scheduled On-Site County Reviews

As part of our Fiscal Year 2001 audit, we reviewed the Department's supervision and administration of the TANF/Colorado Works program. We found that the Department is not adequately monitoring county TANF activities. Specifically, the Department discontinued on-site monitoring efforts previously in place. While department staff initially scheduled four on-site county reviews of the TANF program for Fiscal Year 2001, they visited only two counties during the fiscal year and did not complete final reports to the counties or address identified problems with county staff.

The lack of follow-up is especially troubling due to the number and nature of the problems identified through the Department's reviews. For example, DHS staff noted in the Pueblo review that 31 of the 48 cases selected (65 percent) had discrepancies between the case file and the Colorado Automated Client Tracking Information System (CACTIS) or did not have an Individual Responsibility Contract (IRC) in the file. CACTIS is utilized by the counties to track the status of an individual's work activities. If data from the case file are not entered into CACTIS correctly, then the system lacks adequate information to accurately track federal work requirements. The IRC is a contract between the client and the agency that addresses each party's responsibility. It is required by statute to be in place within 30 days from the date the client is approved for the program and outlines the individual's plan to achieve self-sufficiency. This information is critical for reporting purposes to the federal government.

Department Has Not Reviewed County TANF Fraud and Abuse Standards

We also found that the Department's monitoring of county controls over possible fraud and abuse within the TANF program is lacking. We noted that the Department sent an agency letter to each county in July 2000 requiring them to establish and maintain standards and procedures to safeguard against program fraud and abuse. Counties were to submit the standards and procedures to the Department in order that DHS staff could review and monitor them for compliance with the State Plan. However, the Department did not specify a due date for submission of the standards and procedures. We found that a year after sending the letter the Department had not received or reviewed any of the requested information from the counties. Further, although the Department indicated in its letter that it would be developing formal review and tracking processes and establishing a monitoring schedule, the Department has not developed and documented review or tracking processes or created a monitoring schedule for reviews of fraud procedures and cases.

The lack of established procedures and monitoring for fraud and abuse is a serious concern. Under the Colorado Works program, counties have been given the authority and responsibility for handling their own fraud cases, and the Department has only limited information on these cases. In addition, county personnel have considerable discretion in the types of payments that can be made to beneficiaries under the program. Without an effective fraud and abuse prevention program in place at the county level, the Department cannot ensure that counties have the necessary policies and procedures in place to monitor the activities of program personnel with regard to the appropriate use of TANF funds.

Monitoring Problems Were Identified in 1998 Audit

Problems with the Department's monitoring of the TANF program have been noted in past audits. During our Fiscal Year 1998 audit, we found that the Department had not developed and implemented an on-site review process for overseeing the counties' implementation and administration of TANF. We recommended at that time that the Department develop and implement a formalized plan for on-site monitoring for TANF. The Department agreed with our recommendation and created draft monitoring procedures and performed two complete county on-site visits during Fiscal Year 2000. As noted above, however, the Department suspended its on-site monitoring process during Fiscal Year 2001. The Department determined the monitoring model it had developed required too much time to complete and to follow up with counties regarding identified problems. Therefore, the Department is currently reassessing its on-site monitoring process and plans to implement a new plan for on-site county reviews.

On-site monitoring is a critical tool routinely used by DHS and other state agencies to ensure that state and federal requirements are met, particularly for large federal programs. Within DHS, program staff for the Food Stamps program conduct on-site monitoring to determine counties' compliance in areas such as eligibility and benefit payment determination. All counties are subject to review at least once every three years. Similarly, DHS staff for the Adoption Assistance and the Foster Care programs perform on-site monitoring of county activities on a regular basis.

Better Monitoring Could Help Ensure Requirements Are Met

Adequately monitoring county TANF activities is especially important because the State as a whole will be held accountable for meeting federal requirements such as work participation rates; in turn, the State's federal funding is affected by how successfully

federal requirements are met. By reestablishing on-site monitoring, the Department is also more likely to become aware of problems in areas including eligibility determination and benefit payments. For example, through on-site case file reviews, the Department can ensure that an individual's information is correctly entered into the Department's eligibility determination system and that benefit payments are appropriate. In addition, the Department can better determine problem areas and provide appropriate technical assistance. In terms of fraud and abuse activities, the Department's oversight role is critical to ensure TANF funds are used only for allowable purposes. Without an adequate review process over counties' controls in this area, there is a risk that fraud could occur and not be detected.

The Department and the counties have worked hard to develop an informal process in which the counties can communicate with the Department when they need assistance. The Department should supplement this with a formal, on-site county review process for overall program requirements and for fraud and abuse activities to ensure state and federal laws and regulations are met.

Recommendation No. 64:

The Department of Human Services should develop, implement, and maintain a formalized process for on-site monitoring of county activities for the Temporary Assistance for Needy Families (TANF) program to ensure that federal and state requirements are met. This process should include:

a. An established time frame for conducting county reviews to ensure all counties are reviewed within a specified period of time.

b. Specific steps for performing follow-up on problems identified and resolving them in a timely manner.

Department of Human Services Response:

Agree. The Department will reestablish a process for on-site monitoring using the following strategies: the Colorado Works Division will consult with other program areas, e.g. Child Welfare, concerning their use of risk-based monitoring for the purpose of the development of risk criteria that would trigger priority first-year review (or re-review) of counties needing more immediate attention. The Department will also develop a screening tool and modify the current monitoring instrument to assist in targeting the timing and scope of its statewide reviews. On-

site (for large- and medium-sized counties) or case file reviews (for smaller size counties) will be conducted so every county will be reviewed at least once in every four-year period. This approach, we believe, is consistent with our new initiative of Performance Management using critical performance indicators through extensive data reporting and analysis, policy guidance, and county-specific customer-focused technical assistance.

The Department will follow up on problems identified during county reviews by issuing reports to the counties within 60 days of the review and ensuring corrective plans are in place within 60 days after the report has been issued.

Implementation Date: April 1, 2002, and ongoing

Recommendation No. 65:

The Department of Human Services should ensure that adequate controls over fraud and abuse in the TANF program are in place at the counties by:

a. Requiring counties to submit standards and procedures to safeguard against program fraud and abuse within a specified time period.

b. Reviewing these standards and procedures for compliance to the State Plan and providing feedback to the counties as needed.

c. Developing a formal process that includes a monitoring schedule for reviews of county fraud procedures and cases.

d. Following up on problems identified during county reviews as appropriate.

Department of Human Services Response:

a. Agree. The Department will follow through with its previous Agency Letter and establish an ad hoc work group of county representatives to assist the Department in the establishment of standards and procedures to ensure against program fraud and abuse. A subsequent Agency Letter will be provided giving guidance to counties concerning minimal standards and procedures to ensure against program fraud and abuse. Counties will then have 30 days to comply with submittal of county-specific measures.

Implementation Date: April 15, 2002

b. Agree. The Department will review county standards and procedures within 30 days of receipt of such procedure from the county.

   Implementation Date: June 15, 2002

c. Agree. The Department will incorporate this monitoring schedule within its overall on-site monitoring schedule of federal and state requirements.
   Implementation Date: June 15, 2002, and ongoing

d. Agree. The Department will follow up within 30 days of the review by working with the county to ensure proper implementation of standards and procedures.

   Implementation Date: May 15, 2002, and ongoing

Cash Management for Federal Programs Still Problematic

In Fiscal Year 2001 the Department of Human Services expended $609 million in federal funds for the administration and individual benefit payments of 69 federal programs. The State operates on a reimbursement basis with the federal government. This requires that the State use general funds to make expenditures for federal programs and then request reimbursement from the federal government for the appropriate share. State Fiscal Rules and federal regulations require that the Department request reimbursement so that transactions are "interest neutral" for both the federal government and the State, meaning that neither realizes an unfair financial advantage from use of the other entity's funds. According to the State's formal agreement with the federal government, this means that the Department should request reimbursement three business days after state funds are expended for 14 of the Department's largest programs. These programs are covered under the federal Cash Management Improvement Act (CMIA) and include Temporary Assistance to Needy Families (TANF), the Food Stamp Program, Foster Care, and the Child Care Development Fund, among others.

Since Fiscal Year 1995, audits have identified ongoing problems with the Department's cash management related to federal programs. Our Fiscal Year 2001 audit again found similar problems: DHS does not draw federal funds in a timely manner after state funds are expended. This means that the State, in effect, loses interest on general funds that are

used to front expenditures for federal programs prior to the receipt of federal reimbursement.

Federal Receivable Accounts Show Large Balances

We reviewed the accounts receivable balances for the Department's 14 federal programs covered under CMIA requirements as of March 31, April 30, May 31, and June 30, 2001, and calculated the turnaround ratios these balances represented. The turnaround ratio is a standard analytical tool that is used to measure an entity's ability to collect receivables in a timely manner. In this case, we used the turnaround ratio to measure the number of months of average federal revenue in the accounts receivable balance. In other words, the turnaround ratio is the average time it takes the State to collect from the federal government once the state expenditure has occurred. If the Department met the three-business-day draw requirement, this would result in a turnaround ratio of about 0.14 months. We noted problems with all of the Department's 14 programs, and we found problems at the end of all four months reviewed. Five of these programs and their turnaround ratios for the last two months of Fiscal Year 2001 are shown in the table on the next page. For these five programs the Department's turnaround ratios ranged from about nine days to over five months, with the exception of the June 30, 2001, balance for the Foster Care program.

Department of Human Services
Turnaround Ratios for Federal Receivables for Selected Federal Programs
Fiscal Year 2001

Federal Grant	Accounts Receivable Balance		Months of Revenue in Accounts Receivable (Note: Three business days is 0.14 months.)[1]	
	May 31	June 30	May 31	June 30
Temporary Assistance for Needy Families (TANF)	$7,303,222	$8,706,458	0.83	0.99
Social Services Block Grant (Title XX)	$7,722,157	$19,101,617	2.02	5.01
Foster Care (Title IV-E)	$1,721,286	($2,220,388)	0.56	-0.72
Vocational Rehabilitation	$993,428	$2,399,733	0.42	1.02
Child Care Development Fund	$11,463,918	$19,283,601	1.88	3.16

Source: Office of the State Auditor analysis of Department of Human Services data.
[1] Under state and federal requirements, the Department of Human Services should draw federal funds three business days after the related state expenditure is made.

This table illustrates that for four of the five programs the Department is not drawing federal funds in a timely manner. In the case of the Foster Care program, the Department drew federal funds in advance of making state expenditures, which is a violation of federal regulations.

Problems Noted With Federal Drawdown Process

In addition to the problems with the federal accounts receivable balances, we noted the following:

- Staff entered a federal reimbursement rate in the State's accounting system for the Vocational Rehabilitation program that was too high. Because they did not identify and correct the error for a month, this resulted in the Department overdrawing

$243,010 in federal funds. The Department reduced its subsequent federal draw requests to offset the overdraw.

- Because staff established information incorrectly in the State's accounting system, large amounts of expenditures for several programs were not automatically transferred to the federal draw account. As a result, department cash management staff were not aware that these federal funds needed to be drawn and did not request timely reimbursement for those expenditures. We reviewed one transaction that required manual intervention to move approximately $10 million from the federal receivable to the federal draw account.

- Staff entered incorrect coding information into COFRS for certain Food Stamp administration expenditures. As a result, the Department drew $910,000 against the wrong letter of credit, which required numerous adjustments to compensate for the overdraw.

Ensure Cash Draws Are Made Timely

Good management of state and federal funds is a critical function for the State from both a legal compliance and business perspective. The Department plays a significant role in the State's funds management because it receives a large portion of the total federal funds provided to the State. In Fiscal Year 2001, for example, the Department received about 16.9 percent of the nearly $3.6 billion in federal funds the State received.

In order to both meet federal CMIA requirements and serve the best interest of the State, we recommend the Department improve its cash management process by improving its oversight of cash management and federal draw procedures.

Recommendation No. 66:

The Department of Human Services should ensure federal funds are drawn in a timely manner for all federal programs. As part of this, the Department should:

a. Provide effective training and oversight to accounting staff responsible for cash management processes.

b. Ensure information entered into the State's accounting system for cash management is accurate and in accordance with federal drawdown regulations.

Department of Human Services Response:

a. Agree. The Department will schedule and conduct training for all program accounting staff, the cash management accountant, and the cash management accountant's supervisor. In addition, the training will include the oversight procedures and follow-up to problem areas. The Cash Management Program will be included as a part of the monthly/quarterly SCO Diagnostic Report review.

b. Agree. The Department will initiate a comprehensive review with the Department of Treasury to maximize the federal funds draw patterns under the Cash Management Improvement Act (CMIA). The Department will assess the cost/benefit impact of any procedural process changes necessary to achieve CMIA goals.

   Implementation Date: March 31, 2002.

Improve Inventory Process for the Food Distribution Program

The United States Department of Agriculture (USDA) obtains commodities such as peanut butter, chicken, beef, frozen juice, and cheese through price support programs, surpluses within the marketplace, and direct purchases from national markets. The USDA donates these commodities to Food Distribution Programs throughout the United States. In Colorado, the Food Distribution Program within the Department's Office of Self-Sufficiency is responsible for the receipt and distribution of goods under eight federal donated food grants.

As part of our audit, we reviewed the Department's controls over four of the largest federal donated food programs: Food Distribution (CFDA 10.550), National School Lunch Program (CFDA 10.555), Child and Adult Care Food Program (CFDA 10.558), and Summer Food Service Program for Children (CFDA 10.559). During Fiscal Year 2001, DHS distributed $13 million in donated foods under these programs to schools, child and adult day care centers, and other qualifying entities.

Monthly Reconciliation Process Needs Improvement

The Department currently contracts with two commercial distributors for the receipt, storage, and distribution of commodities for its donated food programs. These contracts require that the distributors send daily and monthly reports to the Department's Food Distribution staff. From these reports, Department staff monthly reconcile inventory amounts contained in the contractors' records with Food Distribution Program records to ensure all commodities are appropriately tracked.

As part of our audit, we reviewed the Department's monthly inventory reconciliations for April, May, and June 2001. We found that monthly reconciliations contained significant discrepancies that we were unable to trace through to resolution. For example, the June 2001 reconciliation for one distributor reported warehouse shortages for 15,267 commodities with a value of $262,000 and overages for 15,033 commodities with a value of $239,000. The May 2001 reconciliation for the same distributor reported warehouse overages for 15,781 commodities with a value of $192,500 and shortages for 7,249 commodities with a value of $122,000. Department staff reported that these discrepancies were subsequently resolved; however, staff were unable to provide supporting documentation indicating how these resolutions occurred. As a result, we were unable to confirm that the discrepancies were handled appropriately.

Department staff noted that discrepancies commonly occur for reasons such as timing issues, warehouse staff coding and system entry errors, incomplete warehouse documentation submitted by distributors to the Department, and warehouse shipment errors. Due to the large number of discrepancies and the time and effort required to investigate and resolve them, department staff indicated that reconciling the monthly inventory records can be a lengthy process, ranging from two days to over a month.
Many of the problems mentioned above could be rectified with better inventory policies and procedures. We found that the Department is not providing sufficient guidance and technical assistance to its contracted distributors. While the contract gives distributors general guidelines to follow, the Department has not established and documented inventory procedures for warehouse staff or conducted training sessions for warehouse personnel on correct procedures.

It is essential for the Department to have effective and efficient inventory controls over donated foods to demonstrate accountability for these commodities to the federal government and to ensure goods are not subject to misappropriation. Additionally, implementing better procedures for tracking commodities at the warehouses should lessen

the number of inventory discrepancies, as well as the time required to investigate and resolve them.

Recommendation No. 67:

The Department of Human Services should improve its inventory controls for the Food Distribution Program by:

a. Resolving identified discrepancies and maintaining documentation to support reconciled inventory reports.

b. Developing and documenting formal procedures for tracking commodities at the warehouses, and providing training and technical assistance to distributors.

Department of Human Services Response:

a. Agree. The program staff will document all inventory discrepancies with our two contracted distributors. The program staff will retain documentation detailing exactly how the discrepancy was resolved. This documentation will support the reconciled inventory reports. A copy of the reconciliation and documentation will be supplied to the two contracted distributors each month.

b. Agree. Overage and shortage discrepancies between physical inventory and book inventory shall be reconciled monthly. The contract requires that distributors submit daily their receiver shipment batch files, invoices and credit memos of USDA commodity shipments and monthly their inventory status reports. The contract also allows for liquidated damages when a distributor fails to submit required reports and files. Food Distribution staff will continue to provide technical assistance with distributors on a monthly basis when discrepancies occur and will inform them of discrepancies that they need to resolve. We will begin instituting liquidated damages when discrepancies are not resolved on a timely basis by our distributors. A letter will be sent to both distributors reiterating deadlines and damages.

Implementation Date: November 1, 2001

Segregation of Duties Should Be Applied Within Food Distribution Program

As noted above, the Food Distribution Program within the Department's Office of Self-Sufficiency is responsible for the receipt and distribution of goods under eight federal donated food grants. A staff of six is employed to carry out these responsibilities. We noted during our review of the Department's controls over four of the larger federal donated food programs listed in the previous comment that the Department lacks adequate segregation of duties among Food Distribution staff to ensure state assets are properly safeguarded. Specifically, out of the seven expenditures tested for the Food Distribution Program, we found that in six instances both the purchase of and authorization to pay for these goods and services were made by the same person. The expenditures were for computer consulting services, software, and hardware related to a computer project for the Food Distribution Program. The staff person who authorized the purchase and the payment for the expenditures was overseeing this project. The estimated cost of the project is $176,000, which will be paid by federal and state funds.

Control activities over safeguarding of assets include policies and procedures to prevent unauthorized acquisition, use, or disposition of state assets. When the same individual can authorize both the purchase and payment for goods and services, this presents a risk that improper expenditures could occur. Although our audit did not identify questionable purchases, we believe that the Department should take action to establish appropriate segregation of duties within the Food Distribution Program in order to ensure such instances do not take place.

Recommendation No. 68:

The Department of Human Services should segregate duties within the Food Distribution Program by ensuring that the same individual is not authorized to purchase goods and services and approve invoices for payment.

Department of Human Services Response:

Agree. Food Distribution staff will ensure that the same individual that authorizes the purchase of goods and services is not the same individual that approves the invoices for payment.

Implementation Date: November 1, 2001

Reinstate On-Site Monitoring of Vocational Rehabilitation Field Offices

In Fiscal Year 2001 the Department of Human Services expended over $36 million in total for the operation of the Vocational Rehabilitation Program (CFDA #84.126), which is overseen by the Division of Vocational Rehabilitation. The purpose of this program is to assess, plan, develop, and provide vocational rehabilitation services for individuals with disabilities so they may prepare for employment.

Vocational Rehabilitation services are provided by counselors through the 25 field offices located throughout Colorado. Prior to Fiscal Year 2001 the Department relied on two levels of quality assurance to monitor field office staff activities. The first level consisted of supervisory reviews by staff at the field offices, while the second level consisted of routine on-site quality control reviews of field offices' program activities by Vocational Rehabilitation quality assurance specialists and regional supervisors. Through this monitoring the Department determined compliance with state and federal regulations regarding clients' eligibility, allowability of expenditures, file documentation, Individualized Plan for Employment (IPE) development and appropriateness, and case closures.

We found during our audit that the Department did not perform any on-site reviews through its second level of quality assurance during Fiscal Year 2001. Department staff indicated that as a result of case documentation problems found through a federal Rehabilitation Services Administration (RSA) review of the Department's Vocational Rehabilitation program, they discontinued the on-site reviews at the beginning of the fiscal year to reconsider their monitoring efforts.

In January 2001 the Department informally instituted a more comprehensive supervisory review process over counselors' service or activity assessments at the field office level. The focus of the reviews is to provide proactive coaching and consultation to counselors during the development of a case rather than reviewing for compliance after the case is closed. However, we found that there are no official reporting methods in place to ensure that these reviews are taking place and are effective.

On-Site Monitoring Would Provide Better Assessment of Program Compliance

On-site monitoring is an effective tool for identifying problems occurring statewide and determining areas for increased training. Further, as noted above, various field office staff

administer the Vocational Rehabilitation program on a decentralized basis statewide. By reestablishing its complete on-site monitoring function through reviews performed by quality assurance specialists and regional supervisors, the Department would gain more independent assessments of documentation deficiencies and federal and state compliance than field office supervisor reviews provide. The Department should reinstate its formal case file review process and establish a formal reporting process for field office supervisors related to their reviews to gain assurance that the program is operating effectively and appropriately.

Recommendation No. 69:

The Department of Human Services should improve controls over the Vocational Rehabilitation program to ensure compliance with federal and state regulations by:

a. Reinstating on-site quality assurance reviews of Vocational Rehabilitation field office activities.

b. Documenting and implementing supervisory review procedures to be followed by field office staff, including required reporting.

Department of Human Services Response:

a. Agree. The Division of Vocational Rehabilitation has reinstituted its second-level quality assurance review process whereby a team of managers/QA specialists review and report on compliance of field office vocational rehabilitation service records with state and federal regulations.

b. Agree. Written review and reporting procedures for its first-level quality assurance review process, used by field office supervisors, have been developed.

Implementation Date: July 1, 2001

Improve Fiscal Controls Over Vocational Rehabilitation Reports

As noted in the previous comment, in Fiscal Year 2001 the Colorado Department of Human Services expended over $36 million in state and federal funds for the Vocational

Rehabilitation Program (CFDA #84.126). As part of our audit, we reviewed the Department's controls over financial and performance reporting for the program.

Problems Were Noted With Quarterly and Annual Reports

The Department must file a quarterly financial status report (SF-269) with the federal Rehabilitative Services Administration (RSA). The report contains federal expenditures, state expenditures, and remaining grant award balances for the individual grant program. Also, the Department must annually submit a program cost report (RSA-2) at the end of every federal fiscal year. The report contains the total amount of expenditures made to provide Vocational Rehabilitation services, the total number of individuals with disabilities receiving services and the amount of expenditures on their behalf, and funds remaining from prior fiscal year grant awards. During our Fiscal Year 2001 audit, we noted problems with the Department's reporting processes for these two reports.

For example, we found that supporting documentation for numbers reported on the reports is lacking. Division accounting staff did not maintain documentation showing the methodology used to split total accounts payable of $4.8 million between the state and federal share on the December 31, 2000, financial status report. Therefore, we were unable to determine if the state and federal share amounts reported by the Department were accurate. In addition, the Department could not provide supporting documentation for selected amounts totaling $20.1 million reported on the federal Fiscal Year 2000 program cost report including the number of individuals served and related expenditures by service category, and previous fiscal year program income carried over to the next fiscal year. Program and accounting staff indicated that the original Vocational Rehabilitation system report that was used to prepare the program cost report could not be located, nor could it be reproduced.

We also noted that initial versions of submitted reports frequently contain errors and are then revised and resubmitted after the original due date. We found that the Department submitted revised reports for both the quarter-ending December 31, 2000, financial status report and the federal Fiscal Year 2000 program cost report after the original report due dates. Further, we noted that the revised quarterly financial status report contained a $1,000 mathematical error. In addition, we noted that as a result of a federal RSA review of the Division in Fiscal Year 2000, the Division was required to submit revised financial status reports for Fiscal Years 1997, 1998, and 1999, and revised program cost reports for federal Fiscal Years 1997 and 1998 due to errors including inaccurate reporting of the nonfederal share of net outlays and funds carried over from a previous fiscal year. While we recognize that the Department corrects and resubmits federal reports on a regular basis

due to final information obtained after initial due dates, the frequent submitting of reports containing errors indicates that the Department lacks effective controls over Vocational Rehabilitation reporting to enable it to file correct reports upon initial submission and within required time frames.

Federal Review Placed Vocational Rehabilitation on Corrective Action for Federal Reporting

As stated above, federal RSA staff conducted an annual review of the Vocational Rehabilitation Program during Fiscal Year 2000. As a result of the federal review, the Department was placed on corrective action for a lack of adequate fiscal controls to provide accurate and timely reports. The corrective action required Vocational Rehabilitation to establish effective fiscal controls and financial and accounting procedures that will result in accurate reports in compliance with federal regulations. The Department agreed it would improve the accuracy and timeliness of its fiscal reports as of August 2001.

Better Fiscal Controls Could Help Ensure Accurate and Timely Financial Reporting

Problems with inaccurate reporting and insufficient supporting documentation need to be addressed by the Department. Federal regulations require that the State maintain effective fiscal controls and accounting procedures to ensure reports are accurate and submitted timely, and demonstrate accountability for how state and federal funds are used.

Recommendation No. 70:

The Department of Human Services should strengthen its fiscal controls and accounting procedures over reporting for the Vocational Rehabilitation Program by:

a. Maintaining adequate documentation to support amounts reported on the quarterly financial status reports and annual program cost reports.

b. Reviewing reports prior to submission to ensure accurate information is submitted to the federal government.

c. Documenting specific procedures for the preparation of the financial status and program cost reports.

Department of Human Services Response:

Agree. The Department will develop a desk procedure manual for each staff person in the Program Accounting Section of the Division of Accounting. The Desk Procedure Manual will include, but not be limited to, the preparation of the financial status and program cost reports ensuring that adequate supporting documentation is maintained. Included in this procedure will be the requirement for review and approval by the immediate supervisor.

Implementation Date: March 31, 2002

County Financial Management System

The County Financial Management System (CFMS), which was implemented in July 1999, serves as the Department's data repository to accumulate benefit and benefit-related expenditure data. CFMS is used to account for approximately $750 million annually in these benefit and benefit-related expenditures. The CFMS general ledger houses all fiscal and financial data for all public assistance programs administered within the Department. Information from the CFMS general ledger is ultimately downloaded to the Colorado Financial Reporting System (COFRS) for state and federal reporting.

The following comments were prepared by the public accounting firm of KPMG LLP, who performed audit work at the Department of Human Services. The comments were contained in the *Colorado Department of Human Services, County Financial Management System Performance Audit*, Report No.1275, dated June 2000.

Policies and Procedures

Policies and procedures are critical in establishing an infrastructure for a sound internal control environment. In the absence of formally documented policies and procedures, clear guidance on acceptable practices is not in place to evaluate current activities. Procedure manuals should contain sufficient information to enable personnel to understand, control, and operate CFMS.

Our procedures included obtaining DHS's documented policies and procedures related to the input, processing, and output of data from CFMS, and policies and procedures related to application change management and security administration over CFMS. We compared the documented policies and procedures with the current practices utilized by

personnel to determine if the actual procedures utilized are consistent with those documented. In addition, we tested several items related to CFMS transactions, application change management, and security administration to determine compliance with documented policies.

We noted the Department does not have formal policies and procedures in the following areas related to CFMS:

- **Authorization to access output.** One of the primary goals of CFMS is to make more information available to users in a more timely manner in the form of online inquiries and ad hoc reports. With the increase in the amount of information provided by CFMS comes the responsibility to develop policies and procedures to effectively manage the accessibility of this information. We noted policies and procedures related to output accessibility authorization for CFMS and the Client Fiscal Repository (CFR) have not been formally documented.

- **Reconciliation of CEDS (County Employee Data Store) / county payroll output.** Reconciliation of data between source documents/systems and reporting systems is a primary control used to ensure that all data have been processed completely and accurately. While policies and procedures exist related to reconciliation of output in all other transaction flows related to CFMS, DHS does not have policies and procedures related to the reconciliation of CEDS output.

In addition, we noted DHS has incomplete or limited policies and procedures in the following area related to CFMS:

- **Input completeness and accuracy for transactions input through the open interface (benefit transactions), CEDS transactions, and state journal entries.** The policies and procedures related to the input of transactions to CFMS do not address procedures to ensure the completeness and accuracy of the transaction input. Current policies and procedures do not describe the individuals responsible for the verification of completeness and accuracy, nor do they address the specific procedures and reports used to perform this function.

Finally, we noted DHS does not consistently follow policies and procedures in the following areas related to CFMS:

- **County input authorization.** Input authorization policies and procedures exist at the county level, but we noted they are not consistently followed. During the course of our procedures, we noted the two invoices selected for testwork at the

county level did not contain the appropriate authorization prior to input to CFMS as required by documented policies and procedures.

- **Input error correction for transactions input through the open interface (benefit transactions).** Input error correction policies and procedures are not followed on a consistent basis. During the course of our procedures, we noted journal vouchers were not processed to move three of the four transactions from the default error correction account to the correct general ledger account as required by documented policies and procedures.

- **Accuracy and completeness of output for transactions input through the open interface (benefit transactions).** Output accuracy and completeness policies and procedures for the open interface exist, but we noted they are not consistently followed. During the course of our procedures, we noted monthly reconciliation of the open interface transactions to the general ledger was not performed in a timely manner as required by documented policies and procedures. We noted that although the reconciliation has been completed through April 2000, the reconciliation process was just recently performed in aggregate for the period of July 1999 through April 2000. The transactions for that period represented approximately $357 million of benefit and benefit-related expenditures.

Recommendation No. 71:

The Department of Human Services should:

a. Develop and/or formalize policies and procedures for all CFMS functional areas; policies and procedures should contain sufficient information to enable personnel to understand, control, and operate CFMS.

b. Perform a comprehensive review of existing policies and procedures; where deemed inadequate, new formal policies and procedures should be developed and implemented.

c. Perform periodic reviews of policies and procedures to ensure they are current in light of prevailing business practices.

d. Establish a process to monitor compliance with policies and procedures.

Department of Human Services Response:

Agree. Formal, current comprehensive policies and procedures will be completed for all CFMS functional areas. In addition, a process will be established whereby compliance with policies and procedures is monitored on a periodic basis. A staff member will be assigned to this project in September with anticipated completion by December 31, 2000.

Change Management and Database Administration

DHS has contracted with DynCorp, a technology services company, to provide database administration support and related services, including maintenance of the operating system and any changes associated with the CFMS applications, database, and operating system. These services are collectively referred to as Database Administration and Application Change Management. The service contract between the Department and DynCorp commenced in November 1998. The contract has a provision for four one-year renewal options, potentially extending these services through December 2004.

DynCorp's responsibility related to database administration covers the physical design and management of the database. It also includes the evaluation, selection, and implementation of the Database Management System (DBMS). DBMS is software that controls the organization, storage, retrieval, security, and integrity of data in a database. It accepts requests from the application and instructs the operating system to transfer the appropriate data. DBMS lets information systems be changed more easily as the organization's requirements change. New categories of data can be added to the database without disruption to the existing system. The major features of a DBMS include:

1) *Data Security* – The DBMS can prevent unauthorized users from viewing or updating the database.

2) *Data Integrity* – The DBMS can ensure that no more than one user can update the same record at the same time, and ensures that the database does not keep duplicate records.

3) *Interactive Query* – Most DBMS provide query languages and report writers that let users interactively interrogate the database and analyze its data. This important

feature provides management with the ability to grant users access to information, as needed.

4) *Data Independence* – With a DBMS, the details of the data structure are not stated in each application program. The program asks the DBMS for data by field name, but without a DBMS, a programmer must reserve space for the full structure of the record in the program. Any change in data structure would require changing all application programs.

Another primary area of responsibility of DynCorp is administration of the change management process for the applications, operating system, and database. Change management, in general, encompasses the process of identifying, reviewing, approving, categorizing, prioritizing, and executing changes to the CFMS environment. The execution of approved change requests should be done in a manner that effectively prevents or significantly reduces the risk that unauthorized or unintentional changes are made to the CFMS environment. This is particularly critical for DHS, an organization responsible for the timely disbursement of a high volume of welfare and related Human Services commitments. Best practices dictate that the change management process is administered through the use of dedicated version control software.

Included in our procedures were the review and testing of application change management and database administration, two of the areas administered by DynCorp. Adequate controls surrounding application change management reduce the risk of unintentional or unapproved modifications of systems and data, potentially causing a system to be unavailable for its intended purpose. Adequate database administration provides the efficient and effective performance of the associated user applications and operating system.

Regarding application change management and database administration, we noted findings in the following areas:

- Database Access
- Application Change Management
- Database Administration Policies and Procedures
- UNIX Administration
- Use of Audit Capabilities Surrounding the Oracle Database

Complete descriptions of the findings in these areas, our recommendations, and DHS's responses are detailed below.

Database Access

We noted the following related to unauthorized database access:

- DynCorp programmers/developers have access to the CFMS production environment. Because programmers/developers can effectively change the way an application processes data, best practices dictate that programmers/developers have access only to a test environment, not the production environment where data integrity can be compromised.

- Two DHS employees have database-level access that was not supported by an approved access setup form.

- Database passwords are not changed on a routine basis. Best practices dictate that database passwords be changed at least every 30 days.

- Three UNIX user IDs contain passwords that had not been changed since CFMS went into production in July 1999. Best practices dictate that UNIX passwords be changed at least every 30 days.

The database contains information that is deemed critical or sensitive in nature, including master files of vendors, benefit recipient data, and payroll records. Due to the sensitive nature of the information, access to the database should be closely controlled and monitored. Inadequate security control increases the risk of users with access and capabilities not compatible with their job responsibilities, inappropriate access to information resources, compromised data integrity, and unauthorized modification of data or programs.

Recommendation No. 72:

The Department of Human Services should require DynCorp to review the current database access structure to ensure that appropriate segregation of duties exists in order to exclude the possibility for a single individual to subvert a critical process. In addition, we recommend the Department establish procedures that require appropriate authorization of logical access requests to sensitive or critical information. We further recommend, as part of a formalized database administration security policy, that the Department change database passwords periodically to provide additional access control. These control procedures help reduce the risk that users are granted unauthorized access or access that is incompatible or inappropriate for their job responsibilities.

Department of Human Services Response:

Agree. DHS will establish a security plan that ensures adequate segregation of duties in order to exclude the possibility for a single individual to subvert a critical process. Procedures will be established that require password changes every 90 days. The security plan will be developed by October 31, 2000, and implemented by December 31, 2000.

Application Change Management

We noted the following related to application change management:

- The current outsourcing arrangement between DHS and DynCorp does not specify responsibility for application change management, although DynCorp is performing the application change management function.

- Of 15 application change requests selected for testing, 7 of the 15 did not have documentation, and another 7 of the 15 had incomplete documentation. Required documentation as stated in DHS policies and procedures includes change request approval, evidence of successful testing, approved request to migrate change to production, and evidence of successful migration to production.

- DHS's application change management policies and procedures indicate that version control software is used for the tracking of application and related changes resulting from approved change requests. Currently DynCorp is not using version control software.

Change management performed at the application, database, and operating system level should be tightly monitored and controlled and should be definitively and specifically assigned. Appropriate change management policies and procedures help reduce the risk of unauthorized or unintentional modification of systems and data, helping to ensure continuity of operations as well as data integrity and accuracy. An effective application change management process helps to ensure that all changes are intentional, authorized, and controlled. A major component of an effective application change management process is version control software, which is designed to track, monitor, and control configuration baseline integrity and establish an infrastructure for programmed access authorization controls over the change management system.

Recommendation No. 73:

The Department of Human Services should consider a modification of its service-level agreement with DynCorp to include responsibilities regarding application change management. The responsibility and adherence to stated policies should be definitively and specifically assigned in the agreement. We recommend the Department address this issue before the next contract extension.

Department of Human Services Response:

Agree. The very aggressive project implementation schedule which was required did not allow for a pilot stage. As a result, during the several month period subsequent to implementation, numerous discoveries were made which resulted in a frenetic pace of analysis, development, testing and placing new reports and edits into the production system. While formal documentation of changes has been lacking, the control over the system has been strengthened. Change management software has been procured and a formal change management system will be in place within approximately six months. However, centralized approval for change management was established during January/February 2000, and no production change is allowed without written approval from the project manager. Discussion with DynCorp regarding the administration of the system has already taken place and this will be a topic for contract clarification at the December 31st renewal deadline. Ultimate authority over change management will reside with CFMS project management and enforcement of the methodology will be the responsibility of DynCorp staff.

Recommendation No. 74:

Additionally, the Department of Human Services should require DynCorp to strengthen adherence to its application change management policies and procedures to reduce the risk of unauthorized or unintended changes to the CFMS application, database, or operating system.

Department of Human Services Response:

Agree. This recommendation follows naturally and is addressed in our response to recommendation No. 73.

Database Administration Policies and Procedures

We noted the Department does not have policies and procedures governing database administration and security. Policies and procedures are critical in establishing an infrastructure of control. In the absence of formally documented policies and procedures, clear guidance on acceptable practices for which to evaluate current activities has not been established.

The ongoing presence and function of a formally defined process of database administration and related change management, with clear assignment of these responsibilities, ensures the continuing operation of CFMS and ensures that all system changes are intentional and authorized. Defined and assigned responsibilities reduce the risk of unintentional system modification and risk of unscheduled system unavailability.

Recommendation No. 75:

The Department of Human Services should work with DynCorp to develop and/or formalize policies and procedures for all functional areas relevant to the administration of the CFMS database. Procedure manuals should contain sufficient information to enable personnel to understand, control, and operate CFMS.

Department of Human Services Response*:*

Agree. DHS is in the process of developing departmental standards for database administration at the present time. Once those standards are finalized, database administration of CFMS will conform to them. In the interim, prudent practice coupled with invocation of automated scheduling software (under way) is in place. These standards will be completed and adopted by June 30, 2001.

UNIX Administration

We noted the Department does not have a designated CFMS UNIX administrator position, and has not since the inception of CFMS. UNIX is the operating system used to control CFMS workstations and servers. The UNIX administrator is responsible for overseeing all functions related to UNIX. The role of the UNIX administrator is paramount to helping ensure the effective control and efficiency of the CFMS operating system.

UNIX is a multi-user, multi-tasking operating system that is widely used as a control program in workstations and servers. It is generally known for a variety of versions, as compared to other operating systems. The UNIX operating system is a critical component to the effective operation of CFMS. The UNIX administrator oversees and maintains the operating system, installs patches, monitors system performance, analyzes trends that can significantly affect system performance, and provides feedback to continued effective operation. Properly defined and executed UNIX system administration reduces the risk of inadequate tracking and maintenance of CFMS. Additionally, it reduces the risk of unscheduled system unavailability.

Recommendation No. 76:

The Department of Human Services should designate a UNIX administration position and fill the position appropriately, either in-house or through the outsourcing arrangement with DynCorp. It is likely this position would be outsourced to DynCorp based on the nature of the services provided by DynCorp. We recommend the Department designate a UNIX administration role and, if appropriate, include the position in the service-level agreement between DHS and DynCorp. The service-level agreement should specify the role and responsibilities of the UNIX administrator and should include appropriate funding of the position in the fees paid to DynCorp.

Department of Human Services Response:

Agree. The Department requested funding for a full-time UNIX administrator as of Fiscal Year 2001 decision item. The funding was approved but at a drastically reduced level so as to allow only a few hours of UNIX administration per month. As of September 1, 2000, the Department has used the available funding and leveraged existing departmental resources to perform the duties critical to this function. The Department will continue to request funding for a full-time UNIX administrator for future fiscal years.

Use of Audit Capabilities Surrounding the Oracle Database

We noted DHS is not currently utilizing Oracle audit functionality, AuditTrail®. Sound security policies and procedures should include a formal and executed plan to monitor database access. In the absence of appropriate monitoring, unauthorized or unintentional changes to the database may go undetected. Since AuditTrail® is currently installed, in

order to facilitate the audit functionality, the Department need only modify the current database settings.

Recommendation No. 77:

The Department of Human Services should consider utilizing AuditTrail®, an Oracle functionality that provides a tracking mechanism for changes made directly to the CFMS database. Changes made directly to the CFMS database are not subject to application-level audit trails that capture change information for routine transaction flows. Additional functionality, such as that provided by AuditTrail®, is necessary to capture complete information regarding database changes.

The audit functionality can be used selectively for defined tables, or sets of information. Database tables that hold critical data or which should be selectively or infrequently modified should be considered for audit tracking. Because the use of this function will impact system performance, management should use this function on a selective basis.

Department of Human Services Response:

Agree. Generally, the audit function maintains a transactional level record of all database activity. As a result, there can be considerable overhead in terms of processor time and/or disk storage space which can degrade end user performance. The Department has requested that an analysis of the potential performance cost and disk overhead be performed and that this be done in relation to the projected system load in comparison to original capacity requirement estimates. The CFMS executive management team will be presented with the result and will make a policy determination related to the full or partial utilization in comparison to the potential risks of not utilizing the audit feature. The cost-benefit analysis will be completed by October 31, 2000.

Application User Access Security

DHS has designated a single security administrator through which all CFMS application access requests are to be processed. DHS submits application access requests through the DHS Help Desk. The Application Information Access form includes a listing of the required access responsibilities as well as a signature from that individual's supervisor or manager, indicating approval of the requested access responsibilities. The form has pre-listed the more commonly used access responsibilities, while higher-access responsibilities

that are less commonly granted must be manually noted on the form. Employee job changes, terminations, and related modifications are also to be administered through the Help Desk, using the same procedure.

Security at any level of a computer system has many facets. The application level of a system is of critical importance as the majority of users and data input is typically done at this level. Facets of security include the following:

1. Secrecy and confidentiality: Data should not be disclosed to anyone not authorized to access it.

2. Accuracy, integrity and authenticity: Accuracy and integrity mean data cannot be maliciously or accidentally corrupted or modified. Authenticity is a variant on this concept and provides a way to verify the origin of the data.

3. Availability and recoverability: Systems keep working and data can be recovered efficiently and completely, with no loss of accuracy or integrity, in case of data loss.

The Department executes application-level security via assignment of user rights that are part of a defined Oracle access known as a "responsibility." Setting up a new user requires (1) defining an individual user, and (2) assigning an access responsibility to that user. DHS assigns defined responsibilities to application privileges that define the functional capabilities that the user may execute; for example, invoice input, journal input, or journal approval and posting.

CFMS data are accessed and modified primarily through the related applications, as opposed to accessing the database directly. Strong administration of user access reduces the risk of unauthorized access as well as the risk of access granted to a user that is inconsistent or improper for that user's specific job responsibilities.

Our procedures included obtaining available documentation related to application user access security policies and procedures and testing a sample of application users to determine if DHS granted access that is consistent with documented policies.

Within the area of user access security, we noted the following:

- Eight of twenty-five users did not have appropriate authorization for the responsibilities they were granted.

- One super user and one system administrator were among the users noted above who did not have appropriate authorization for the responsibilities they were

granted. Super users and system administrators have enhanced access to the system, allowing them to perform any and all operations on the computer. Super user and system administrator access should be granted selectively, and extra precaution should be used to ensure that access is appropriate.

- One of three CEDS (county payroll) users selected did not have approval for CEDS access on their access setup forms.

- Two of twenty-three system administrators had not accessed CFMS in over 120 days. Best practices dictate that access not used for 120 days be reviewed and access be revoked as necessary.

- Three generic IDs with published passwords allowing access to CFMS applications. Best practices dictate that generic IDs should not be used.

Unauthorized or inappropriate access to CFMS applications increases the risk that data are accessed, viewed, or modified in a manner that is unintentional or unauthorized. Such access can result in concerns regarding the accuracy, integrity, and authenticity of the underlying financial data. In addition, systems may be rendered inoperable and unavailable as a result of unauthorized or unintentional access to systems and data.

Recommendation No. 78:

In order to help reduce the risk of unauthorized access, as well as the risk of access granted to a user that is inconsistent, inadequate, or improper for that user's specific job responsibilities, and to maintain adequate accountability for CFMS access, the Department of Human Services should:

a. Strengthen adherence to user access setup policies and procedures.
b. Eliminate all generic user IDs with published password.
c. Review user access periodically to determine appropriateness and to verify that generic IDs are not in existence.

Department of Human Services Response:

Agree. A security plan which addresses all items in the recommendation will be developed by October 31, 2000, and implemented by December 31, 2000.

Segregation of Duties

One of the basic principles of internal controls is segregation of duties. The principle of segregation of duties refers to the idea that conflicting functions within a workplace should be performed by separate individuals. Separate individuals should perform the initiation, approval, custody, and record-keeping functions of a given transaction. In this, segregation of duties attempts to prevent the interaction of key positions that could potentially have a detrimental effect on the organization. People within the organization (insider threats) are the largest category of risk to the integrity of an organization. The principles of segregation are designed to prevent fraud or abuse unless collusion occurs.

On the basis of the performance of our procedures, we noted the Department and counties do not have adequate segregation of duties. We noted several positions related to CFMS input, processing, and output that had recently become vacant or had remained unfilled for several months. It is our understanding that in order to maintain certain processes, the Department and counties used existing personnel to perform functions normally assigned to the vacant positions. The specific duties that were or became vacant during the period covered by our procedures and the related findings are as follows:

- **DHS Cost Accountant.** Responsible for input of CFMS cost allocation and share calculation entries.

  Cost allocation and share calculation entries are statistical entries that transfer or divide accumulated costs to the appropriate general ledger accounts and among the federal, state, and county shares. Normally the cost accountant prepares and enters the transactions, and the manager reviews, approves, and posts the transactions. We noted that the manager of local government accounting input, reviewed, and posted the cost allocation and share calculation entries. An individual at DHS separate from the individual entering these transactions did not review the entries prior to the running of mass allocations and posting to the general ledger.

- **DHS Budget Accountant.** Responsible for input of CFMS budget entries.

  Normally the budget accountant prepares and enters the transactions, and the manager reviews, approves, and posts the transactions. We noted that the manager of local government accounting input, reviewed, and posted the budget entries. An individual at DHS separate from the individual entering these transactions did not review the entries prior to the posting of these entries to the general ledger.

- **DHS Electronic Benefit Transfer (EBT) Accountant.** Responsible for EBT administration and legacy code translation correction.

  The program accountant that processes the journals to correct errors caused by incorrect translations is now also correcting the translation in the absence of an EBT Accountant. An individual performing a separate review would help to ensure that translations are occurring and corrected in a timely manner.

- **County Controller.** Responsible for review and approval of finance department transactions.

  The county controller normally reviews and approves expenditures on the voucher information report to ensure that expenditures are appropriate. In one of the counties where we performed procedures, we noted the county controller position was vacant from April 2000 to June 2000. During the vacancy the individuals that entered the invoices for payment performed this review.

Recommendation No. 79:

The Department of Human Services should perform a periodic review of all open positions within the Department with CFMS responsibilities to ensure all critical duties are performed in a timely manner while maintaining an appropriate segregation of duties. In addition, all positions should have a designated substitute to ensure that critical duties are performed as necessary during an employee absence. Designated substitute or backup personnel should be employees who do not perform conflicting functions.

As it relates to open positions at the county level, although county management is responsible for maintaining an effective internal control environment within the county, the Department is responsible for promoting the effective administration of the programs it supports. These responsibilities extend to the use of CFMS for the input, processing, and output of data as well as compliance with user access security over CFMS. We recommend the Department make the county aware of the instances noted at the county where segregation of duties was compromised and help ensure that the situation has been adequately resolved.

Department of Human Services Response:

Agree. Responsibility for the County Controller resides with the County Director. We will share the breach of segregation of duties with the County Director. We are aware that the County Controller position has been filled. The DHS positions listed: DHS Cost Accountant, DHS Budget Accountant, and DHS Electronic Benefit Transfer Accountant have been filled. Field Audits will include testing to check for segregation of duties on future audits. The DHS security plan will encompass segregation of duties by segregating the post and approve function. However, counties with fewer than five employees may request a waiver from the separation of duties standards by implementing alternative internal control procedures. The alternative control procedures must be outlined in a waiver request that is submitted and approved by the DHS Division of Accounting. This information will be shared with the County Directors by September 30, 2000.

Home and Community Based Services and Home Health Services Overview

As an alternative to nursing facility care, Medicaid-eligible individuals who meet the functional assessment for needing nursing facility level of care can choose to receive supportive services in their home or an alternative living environment outside of a nursing facility. These supportive services are provided to individuals through the Home and Community Based Services (HCBS) and the Home Health programs. Please refer to page 159 for additional background information.

During Fiscal Year 2001 the Office of the State Auditor conducted a performance audit of Home and Community Based Services and Home Health Services. The audit comments below were contained in the *Home and Community Based Services and Home Health Services Performance Audit*, Report No. 1033, dated June 2001.

Oversight of the SEPs

The Home Health and HCBS programs involve a complicated web of interagency involvement. The Department of Health Care Policy and Financing is the lead agency and contracts with other agencies to oversee and provide coordination for HCBS and home health services. Specifically, the Health Facilities Division (the Division) is contracted to oversee and investigate service provider quality of care issues; DHS is contracted to

review the activities of the 25 Single Entry Point agencies (SEPs); and the 25 SEPs are contracted to provide assessment, service planning, and case management services to HCBS program participants. We found several instances where oversight and communication among all agencies involved should be improved.

DHS monitors the SEP contractors under a cooperative (interagency) agreement with the Department of Health Care Policy and Financing. DHS's oversight responsibilities include training, technical assistance, monitoring, and making recommendations to the Department of Health Care Policy and Financing regarding provider certification and financial audits for SEP agencies. Our review concentrated on the oversight components of DHS's review including DHS's monitoring, certification, and financial audits of the SEP agencies. We found room for improvement in several areas.

Financial Compliance Reviews

DHS is responsible for conducting on-site financial compliance reviews (FCRs) for each SEP agency. The factors determining the frequency of the FCRs are mutually agreed upon by DHS and the Department of Health Care Policy and Financing. The review is limited to an examination of the program expenditures and the reimbursement of these costs reported by the SEP system. We identified the following problems with the FCRs:

- **Financial compliance reviews performed by DHS are not timely, consistent, or cost-effective.** The most recent Financial Compliance Reviews conducted at four out of the five SEPs we visited were five years old, conducted in Fiscal Year 1996. Another SEP had their review in Fiscal Year 1999 for the three-year period covering 1997, 1998, and 1999. Additionally, one of the largest SEPs has not had a review since 1996. In total, for the five SEPs we visited, DHS recovered about $400,000 as a result of the compliance reviews. DHS explained that they try to conduct these audits every three to four years, but only one of the five had had a review in that time frame. Since the recoveries resulting from these reviews are significant, the reviews should be conducted annually.

- **SEPs are not reverting the unspent monies without a review.** SEPs are required to revert any funds that they received but did not spend during the Fiscal Year. However, for the five SEPs in our sample area, DHS recovered about $260,000 in funds that the SEPs did not spend and that were not reverted prior to DHS's review. Although there is some confusion between Department of Health Care Policy and Financing and DHS staff as to whether SEPs are reverting funds when compliance reviews are not conducted, our review confirmed that the SEPs are not reverting the funds for years in which they do not receive a financial

compliance review. The Department of Health Care Policy and Financing should include penalties and lost interest in the SEP contracts that ensure SEPs comply with requirements to revert unspent funds.

With HCBS program costs increasing greatly each year, it is imperative that the oversight procedures in place concentrate their efforts on reviewing issues that directly relate to client care and cost control. As a result, we believe that the Department of Human Services should improve the oversight of the SEPs. It is possible that financial compliance reviews could be included as an agreed-upon audit procedure during the counties' annual financial audits. If this were done, DHS could review the results during its desk review of the financial audits. Recoveries from the annual compliance reviews would offset some or all of the costs of the more frequent reviews.

Recommendation No. 80:

The Department of Human Services should work with the Department of Health Care Policy and Financing to identify the most cost-effective methods for having financial compliance reviews completed more frequently. Some options are to (1) include the reviews in the annual financial audits of SEPs. This will likely result in Health Care Policy and Financing providing additional funds for the annual financial audits; or (2) require reviews to be completed each year or on a more frequent basis than is currently being done.

Department of Human Services Response:

Agree. The Department of Human Services will be happy to work with the Department of Health Care Policy and Financing to identify the most cost-effective methods for having financial compliance reviews completed more frequently.

Department of Labor and Employment

Introduction

The Department of Labor and Employment is responsible for promoting and supporting the public economic well-being by providing services to employers and job seekers, and by enforcing laws concerning labor standards, unemployment insurance, workers' compensation, public safety, and consumer protection. Please refer to page 61 in the Financial Statement Findings section for additional background information.

During Fiscal Year 2001 the Office of the State Auditor conducted a performance audit of the Welfare-to-Work program. The audit comments below were contained in the *Welfare-to-Work, Department of Labor and Employment Performance Audit,* Report No. 1375, dated July 2001.

Colorado's Welfare-to-Work Program

The Welfare-to-Work (WtW) grants program was established by Congress to provide additional resources to supplement the welfare reform funds included in the Temporary Assistance for Needy Families (TANF) block grant. The Department of Labor and Employment administers and oversees the State's Welfare-to-Work formula grants. Colorado's WtW program is "a collaborative effort involving the Department of Labor and Employment and the Department of Human Services (DHS), the 63 county departments of human services, and the 18 workforce regions and subregions." In Colorado, workforce development boards are responsible for overseeing the various employment programs operated at the regional workforce centers. There are nine workforce investment regions in the State. Each of these regions has a board that oversees its workforce development activities, including Welfare-to-Work. Colorado delivers most of its WtW programs through these workforce regions.

In Colorado, Welfare-to-Work is one of several programs that provide employment services to the "hard-to-employ." Many of the programs can provide the same services to the "hard-to-employ" population. As a result, coordination of services provided to this population is crucial in ensuring that the State, workforce regions, and counties are

effectively leveraging federal and state funds as well as preventing the duplication of services to clients.

Coordination Between Programs Has Been Difficult in Some Regions

Federal regulations require that WtW activities be effectively coordinated with TANF and other programs. The Department wrote in its State Unified Plan that it "will encourage the local workforce regions to coordinate and integrate their programs and services, but the manner and extent to which this occurs remains a local prerogative." Regional WtW programs may need to coordinate with several different Colorado programs that also provide employment services to low-income individuals, including TANF, the Workforce Investment Act (WIA) programs, Wagner-Peyser, and Employment First.

To prevent duplication and maximize the use of various funding sources, regions that co-enroll clients in WtW and other programs must establish a system for coordinating activities among these programs. It is particularly important that regions coordinate job retention and support services provided to clients. This is because federal regulations only allow grantees to use WtW funds for job retention and support services when these services are not available through any other funding source. Coordination between the various employment and assistance programs is essential in ensuring that WtW funds are being used properly.

We found that coordination between WtW and other programs varies from region to region, primarily because of local decisions. Specifically, we found that WtW staff in some regions, such as Mesa and Pueblo, work closely with other related programs. In these regions, WtW staff regularly meet with staff from TANF, Child Support Enforcement, Vocational Rehabilitation, and Workforce Investment Act (WIA) agencies. Often, WtW staff are housed in the same facility as TANF and WIA. However, other regions we visited did not have as close of a relationship with these other programs. For example:

- There have been problems with the coordination between TANF and WtW programs in the Pikes Peak and Adams regions. According to TANF staff in these regions, the work programs they have in place sufficiently meet the needs of the clients. As a result, these staff believe there is little need for WtW.

- The Arapahoe/Douglas Region has not developed a working relationship with the county child support enforcement agency because the local county commissioners have chosen not to serve noncustodial parents in WtW.

Coordination is particularly important when clients are co-enrolled in multiple programs. WtW clients may be co-enrolled in other programs, such as TANF, WIA, and Vocational Rehabilitation. By co-enrolling clients in multiple programs, grantees have the ability to provide a wider range of services to clients. In addition, co-enrolling is particularly beneficial in assisting TANF clients to transition off of public assistance and into long-term employment and self-sufficiency. Colorado WtW staff told us that because many of the TANF clients enrolled in WtW have been receiving public assistance for many years, co-enrolling these clients in both programs gradually eases them off of public assistance and provides necessary supports to ensure better success in WtW.

During the audit we reviewed the various methods used by regions to coordinate WtW services with other employment and assistance programs. Overall, we found that the best coordination efforts between the various employment and assistance programs were in the Mesa, Pueblo, and Weld regions. We identified some effective practices in coordinating these services, preventing duplication, and leveraging multiple sources of funding. These include:

- **Housing Welfare-to-Work in the same location as TANF and other employment and assistance programs.** We found that working relationships between WtW and TANF were often better when staff from these two programs were co-located.

- **Meeting with staff from other programs on a regular basis.** Ongoing communication between WtW and other programs is essential in coordinating the delivery of services and preventing duplication. WtW staff from some of the regions we visited, such as Mesa and Pueblo, regularly meet with staff from other programs to discuss services provided to clients. Staff in Pueblo meet on a weekly basis.

- **Cross-training case managers on the various employment and assistance programs in the region.** A better understanding of the various programs and services available helps case managers better maximize the use of funds on their clients. Case managers in the Weld and Pueblo regions are trained for the various programs available to clients. In these regions case managers assigned to Welfare-to-Work can also provide services from other programs, such as WIA and Vocational Rehabilitation, to their clients directly. In Pueblo one case manager coordinates all TANF and WtW services provided to clients. This approach is used to ensure duplication of services does not occur.

- **Providing case managers access to the automated databases used by employment and assistance programs in the region.** Case managers in some of the regions we visited have access to various automated databases containing client information. For instance, case managers in Weld can obtain client information for TANF and WIA programs. This access allows case managers to determine if a service has been provided to a client and helps to prevent duplication of services.

Local coordination with other programs is a key component of a successful WtW program. As mentioned earlier, federal regulations require effective coordination between WtW and other employment programs. As a result, it is important for the Department to ensure that regions are complying with this requirement. (CFDA No. 17.253)

Recommendation No. 81:

The Department of Labor and Employment should improve coordination efforts between Welfare-to-Work and TANF and other employment programs in the State by:

a. Identifying the workforce regions that are struggling to coordinate Welfare-to-Work activities with TANF and/or other employment programs. The Department should work with TANF and/or other applicable employment programs to determine the reasons for the poor coordination of services.

b. Providing technical assistance to workforce regions that addresses the coordination problems.

c. Ensuring that coordination efforts result in minimizing duplication of services and leveraging of multiple funding sources.

d. Including reviews of coordination efforts in its annual monitoring visits to workforce regions.

e. Formalizing its relationships with its partner state agencies by establishing memorandums of understanding for Welfare-to-Work activities.

Department of Labor and Employment Response:

Agree. Most of the recommended activities are already in place; several were implemented as an integral part of the WtW program's inception.

a. The Department has been and will continue to work with our state partners in TANF and Child Support Enforcement to encourage local coordination to identify training needs and provide technical assistance. For example, the Department of Human Services assisted with the development of the State's WtW plan in 1998. Department of Labor and Employment and Department of Human Services Self Sufficiency Programs have participated in joint teleconferences with the county departments of human services and local workforce regions to discuss program coordination and ways in which the local programs could work together, co-enroll clients, etc. (e.g., October 12, 2000). Department of Labor and Employment, Department of Human Services Self Sufficiency and Department of Human Services Child Support Enforcement have presented joint workshops and participated on panels at each other's conferences and annual meetings (2000 and 2001 Colorado Works Conferences, 2000 and 2001 CSE Conferences, 2000 Fatherhood Initiative Conference, 2000 Rocky Mountain Workforce Association Conference). Child Support Enforcement and the Department issued a joint letter to the county child support enforcement agencies regarding the WtW program and how it could assist in their child support collection efforts (November 1, 1999). The Department of Human Services and the Department of Labor and Employment have jointly visited workforce regions to help facilitate local discussions on program coordination. The Department also worked with the Division of Housing's implementation of its HUD WtW program in 1999.

b. The Department has provided ongoing technical assistance regarding program coordination since the program's inception. For example, the Department began holding periodic meetings with the local WtW coordinators to discuss issues and share ideas in 1998, and has expanded attendance at these meetings to include any interested state and local partners and community-based organizations. During on-site training last year on the new eligibility, regions were encouraged to invite their local partners. The Department of Labor and Employment and the Department of Human Services have presented several workshops at the annual Colorado Works and Rocky Mountain Workforce Development

Association conferences on ways to coordinate programs and services. Local workforce regions have asked the Department to facilitate meetings with their partners to discuss local coordination efforts.

c. See b. above

d. The Department already monitors the nine workforce regions annually. It will include local coordination activities as part of all future reviews.

e. The Department will establish Memorandums of Understanding (MOUs) with each of its state WtW partners by December 31, 2001.

Delays in the Delivery of Paychecks Cause Problems for Clients

During our visit to the Pueblo Subregion, we identified problems with the delivery of paychecks to clients in subsidized employment. Several regions throughout the State place WtW clients in subsidized employment. The wages of these clients are either partially or fully paid with WtW funds. One of the regions that places the most clients in subsidized employment is Pueblo. Pueblo is also one of four service delivery areas within the Rural Region where staff from the Department administer the WtW program. The financial duties for these areas have been assigned to one staff member in the department headquarters in Denver. This individual is responsible for processing paychecks for clients in subsidized employment.

During our visit to the Pueblo Subregion, we obtained a memorandum from a WtW case manager to the Director of the Pueblo Workforce Center. This memo, dated December 15, 2000, stated:

> Many of my clients, who are enrolled in the WtW program, do not receive their paychecks on a regular schedule. I get calls from them sometimes as late as the Thursday following the mailing of their checks informing me they have not received their checks. Often times the lateness of the checks generates additional late fee costs and stress for my clients. [This] also takes much of my work time following up with each situation. One of the most common goals for many of my WtW clients is for them to learn how to budget and manage their money. This late paycheck situation is not conducive to their achieving this goal.

We reviewed three letters that this case manager attached to her memorandum. In all three letters, clients stated that they had received paychecks late. Two clients stated that the late paycheck affected their timely payment of bills. Department staff have followed up on these cases and do not believe they represent widespread problems.

Clients in WtW have limited financial resources. A late paycheck can affect their lives. In fact, we identified some of the hardships that clients face when not receiving their paychecks on a timely or regular schedule. Specifically:

- **Late paychecks can affect clients' housing.** During our visit to the Pueblo Subregion, we identified four clients who paid their rent late because of delays in receiving their paychecks. All of these clients were charged late fees by their landlords.

- **TANF clients in the Pueblo Subregion can temporarily lose their cash assistance if they receive their paychecks late.** We identified four cases in the Pueblo Subregion where clients who were co-enrolled in WtW and TANF temporarily lost their cash assistance due to receiving their paychecks late. Specifically, these clients were supposed to receive a paycheck during one month, but did not receive it until the next month. This resulted in these clients' receiving three paychecks in one month rather than the normal two paychecks. TANF cash benefits are calculated on monthly earnings. The TANF system will automatically cancel a client's cash assistance if the client's monthly earnings are above the allowable amount to be eligible. According to Department staff, there may be some confusion in Pueblo as to when income earned by TANF recipients should be counted. Department of Human Services staff state that it should be counted on the date the income becomes legally available to the recipient (i.e., the date on the check). However, it appears TANF case managers in Pueblo are calculating earned income on the date it is received by the recipient.

- **Food Stamp assistance can be interrupted when clients receive their paychecks late.** Similar to TANF cash assistance, Food Stamps benefits are calculated based on monthly earnings. Clients enrolled in WtW and receiving Food Stamps can face the same consequences as TANF clients when receiving their paychecks late. Staff from the Pueblo Subregion reported that some WtW clients temporarily and unnecessarily lost their food stamp benefits due to delays in receiving their paychecks one month and receiving too many paychecks the next month.

The Department Needs to Solve Payroll Delivery Problems

We found that the payroll delays were primarily caused by the methods used to deliver these paychecks to clients. Specifically, staff in Denver and Pueblo reported that they have experienced a number of problems with sending and receiving mail. The staff members stated that mail containing the payroll information sometimes does not arrive in Denver for as long as two weeks after it was sent from Pueblo. Staff in the Denver office and Pueblo Subregion have primarily used the regular U.S. mail to send payroll documents. On a few occasions, staff from the Pueblo Subregion have used Federal Express to send the payroll information to Denver. However, staff from Denver state that these packages sometimes do not arrive at the Denver office for several days to a week after they were sent. Further, paychecks sent from the Denver office to clients are sometimes delayed in the mail system.

Some of the alternative solutions to the problems with delivering paychecks to clients in the Pueblo Subregion include:

- Using alternative mail systems to deliver payroll documents.
- Sending paychecks to clients electronically.
- Clarifying how TANF staff in Pueblo determine when earned income is counted (i.e., when the check is issued or when it is received by the client).

The current procedures used by the Department to deliver paychecks to clients in Pueblo are not working optimally. The Department immediately needs to identify and implement solutions to these payroll issues. (CFDA No. 17.253)

Recommendation No. 82:

The Department of Labor and Employment should identify and implement solutions to ensure the timely delivery of payroll documents to Welfare-to-Work clients. These solutions may include:

- Using an alternative mail system, such as an express mail courier, to deliver payroll documents to Pueblo staff and directly to the staff in the Denver office.

- Considering using an electronic system to deliver payroll documents to clients who have obtained bank accounts. The Department should assist regions in identifying ways to establish bank accounts for clients.

- Working with TANF staff in Pueblo to clarify how earned income should be calculated for TANF benefits.

Department of Labor and Employment Response:

Partially agree. The Department requested specific documentation regarding this issue and what constitutes "lateness," and was provided the names of four clients. In the absence of specific information, the Department conducted an in-depth review of these four cases, including an analysis of their timesheets and pay records. All but two paychecks were paid within one week following the end of the pay period. Both of the late payments had extenuating circumstances: One involved a client who was terminated from her position and waited two weeks to return to the worksite to get the employer's signature because she was "embarrassed" to go back. The other late payment was due to a staff oversight; however, the case manager took immediate action, the client received her paycheck within two days of the discovery, and the case manager offered to take care of the rent and any late charges, although this assistance was refused.

The Department provides special accommodations to ensure that clients receive payment as quickly as possible, and it has procedures in place to pay rent and late fees when payment is late, although clients do not always accept this offer of assistance. The Department is concerned about the issue of late payments, but needs to analyze it further because there are a number of contributing factors involved, and no easy solution. The Department has taken steps to minimize the impact on clients while it studies the issue:

- Special accommodations have been in place since the advent of subsidized employment so that clients do not have to wait until the end of the next pay period to receive their paycheck. The Department accepts faxed paperwork and processes payroll requests when they are received.

- The Department is investigating the feasibility of developing an electronic transmission system for payroll processing. However, many WtW clients do not have bank accounts, so it is also looking for ways to assist clients in obtaining and managing bank accounts.

- The Department is considering the possibility of creating an impressed cash fund and use of a courier service to deliver time sheets to Denver.

- The Department is currently required to use the GSS mail system, which has resulted in mailing delays. The Department has requested a waiver to allow direct mailing for checks so they can be sent as soon as they are issued.

- The issue of client responsibility must also be taken into consideration. One of the purposes of WtW is to expose clients to workplace expectations, such as the importance of meeting deadlines and submitting time sheets both accurately and in a timely manner, and in learning how to manage their personal finances. The Department will encourage local workforce regions to address these issues in their job readiness training, and to provide personal financial management and budgeting as a post-employment activity.

- The main purpose of welfare reform is to reduce the number of individuals who receive public assistance; WtW was created to provide a network of post-employment supports to assist clients with the transition from welfare to self-sufficiency. Local staff will be encouraged to meet with county human services staff to discuss program requirements and the impact that subsidized employment can have on eligibility for TANF and Food Stamps, ensure that clients fully understand the potential impact that earnings can have on benefits, and develop strategies to minimize adverse impacts on clients.

Ongoing Monitoring Helps Ensure Quality Programs and Compliance With Regulations

Federal regulations and state policies require the Department and workforce regions to conduct ongoing monitoring of the WtW programs. Overall, we found that the Department and workforce regions could improve their monitoring of the WtW programs in the State. Additionally, the Department has not ensured that the regions implement recommendations from monitoring reviews.

The Department conducted on-site reviews of WtW programs in all nine workforce regions. The Department's on-site reviews primarily focused on regional compliance with spending, eligibility, and allowable services requirements. Following each review, the

Department prepared a brief report summarizing the results and making recommendations for improvements. In addition, the WtW Coordinator conducted desk reviews of the financial records of the nine workforce regions on an ongoing basis to ensure compliance with the federal administrative limits and 70-30 spending requirements.

Although the Department has conducted on-site monitoring reviews of some WtW programs in the State, it has not done enough to ensure that WtW programs are in compliance with federal and state requirements. Specifically, we found that:

- **The Department has not conducted on-site monitoring reviews of all of the WtW programs in the State.** The on-site review of the Rural Region included visits to five of the ten subregions. As a result, some of this Region's programs were not monitored. For example, the Department has not conducted programmatic, compliance, or financial reviews of the WtW program in the Pueblo Subregion. As previously discussed, we identified problems with how the program in this Subregion is being administered, particularly with the methods used to deliver paychecks to clients in subsidized employment. Department management were unaware of these problems. If Department staff had monitored Pueblo's program, the problems could have been discovered earlier. It is important for the Department to conduct on-site reviews of subregions within the Rural Region because these subregions are administered differently. Additionally, the purpose of monitoring reviews is to ensure compliance with requirements as well as to improve the quality of the services provided by the programs.

  Department staff stated they plan to monitor all WtW every two to three years. However, the Department has not incorporated this plan into its policies.

- **The Department has not ensured that regions implement recommendations from state or federal reviews.** During our visits we found evidence that some of the deficiencies noted in the Department's or in USDOL's monitoring reports have not been corrected. According to Department staff, none of the deficiencies noted during the reviews resulted in corrective actions. Staff explained that if there is a corrective action, a plan is developed detailing how the region will correct the problem. Department staff stated that they will conduct a follow-up site visit to ensure that the problem has been corrected. If Department staff provide recommendations to improve how the program is administered and there are no corrective actions involved, then staff will not follow up on the recommendations until the next scheduled on-site visit to the region.

To ensure all programmatic, compliance, and financial problems are corrected, the Department needs to follow up with regions on the implementation status of the recommendations made by USDOL and itself. At a minimum, Department staff should obtain supporting documentation from the regions within six months of the review that shows that recommendations have been implemented.

- **The Department has not conducted any on-site monitoring reviews of financial records maintained by workforce regions on their WtW programs.** As mentioned earlier, the WtW Coordinator conducts desk reviews of the WtW financial data for the regions. The financial information used for these desk reviews are self-reported from the regions. As of our audit, Department staff had not verified that the reported financial information is accurate. We identified some instances during the audit where financial information was reported incorrectly or was questionable. As mentioned earlier, WtW has strict spending requirements. USDOL can require grantees to reimburse them for expenditures that are not allowable. As a result, it is important for the Department to ensure that expenditures reported by regions are accurate. Department staff stated that they plan to conduct on-site reviews beginning in July 2001.

- **Workforce regions have not conducted on-site monitoring of their WtW subrecipients.** Two of the regions we visited—Arapahoe/Douglas and Denver—contract out their WtW programs to community-based organizations. However, neither of these regions have conducted on-site monitoring reviews of their subrecipients. Monitoring of WtW programs in the Arapahoe/Douglas Region primarily consists of desk reviews and/or supervisory reviews of client files. Staff from the Denver Region had not conducted any on-site or desk reviews of their WtW contractors. As of our review, the Denver Region had 9 current WtW contracts and was in the process of developing 16 additional WtW contracts. Staff stated that they plan to conduct these reviews in the near future. As mentioned earlier, the U.S. Department of Labor recently conducted a review of the WtW program in the Denver Region. In its report USDOL criticized the Denver Region for not monitoring its contractors and recommended that the Denver Region "develop a corrective action plan" detailing how this region would strengthen its monitoring procedures.

- **The Department is not ensuring that workforce regions are implementing the monitoring policies and activities described in these regions' WtW plans.** As part of the application process for WtW formula funds, the Department required regions to submit "local plans" describing how they would implement their programs, including a description of how they would monitor their programs. The

Denver Region, for instance, stated in its local plan that monitoring of its subrecipients would include the following: (1) appropriate financial and program activity reports submitted regularly to the contract representative; (2) periodic site visits to include a review of allowable activities as well as a review of randomly selected case records to be sure that activities are being provided to eligible WtW clients; and (3) periodic site or desk reviews of contractor eligibility, program, and finances. As stated above, the Denver Region is not conducting on-site or desk reviews of its contractors' activities. However, we found that the Department did not include any recommendations addressing this issue in its review conducted in the spring of 2000.

- **Workforce regions have not submitted required annual reports to the Department that summarize monitoring activities related to WtW subrecipients.** Contracts between the Department and all the regions, except for the Rural, require regions to submit annual reports on their WtW programs to the Department by September 30 of each year. As part of this report, regions are supposed to include a summary of the monitoring activities related to their subrecipients, any corrective actions taken, and the results of these corrective actions. The Arapahoe/Douglas and Denver Regions have not submitted these reports to the Department as required.

Ongoing monitoring of WtW programs is important for several reasons. Specifically, federal eligibility and spending requirements for WtW are strict. Regular monitoring helps identify compliance issues and correct them before major problems develop. By not periodically monitoring these programs, the State risks not complying with these requirements and possibly being required to reimburse the federal government for unallowable expenditures. In addition, monitoring serves as a quality assurance tool. Ongoing monitoring assists regions in identifying and correcting any problems affecting the delivery of high-quality services to clients.

It is important for the Department to ensure the regular and complete monitoring of WtW programs. In addition, department management needs to ensure that all required reports are submitted to and reviewed by staff, and ensure that all recommendations by the U.S. Department of Labor and the Department related to Colorado's WtW formula grants are implemented. (CFDA No. 17.253)

Recommendation No. 83:

The Department of Labor and Employment should improve how the State's WtW programs are monitored by:

a. Revising its monitoring policies to include the frequency of on-site reviews of all WtW programs in the State.

b. Conducting on-site financial reviews of all WtW programs in the State at least every two years.

c. Ensuring that all workforce regions are monitoring their subrecipients at least annually.

d. Ensuring that all recommendations made by the U.S. Department of Labor and the Department related to Colorado's WtW formula grants are implemented.

Department of Labor and Employment Response:

Agree. Colorado is in compliance with the federal regulations governing monitoring and oversight, and its monitoring activities are consistent with federal policy. USDOL views the State as nine separate regions, and requires the Department to monitor the approved administrative entities (i.e., the nine workforce regions) on a periodic basis for compliance with applicable laws and regulations. The Department was required to develop a state monitoring plan, which was subsequently approved by USDOL in 1999, and to determine its own monitoring activities (e.g., frequency, who will be monitored, and when they will be monitored, etc.).

As a general rule, the first time the Department monitors a new program, the visit is of a technical assistance nature to ensure that the region understands the program. In the case of WtW, the initial monitoring focused upon eligibility and allowable activities, and paralleled the scope and nature of the USDOL reviews. None of the problems noted during these monitoring visits involved compliance issues (e.g., consistent errors in determining eligibility), and were addressed through recommendations and technical assistance. Follow-up on noncompliance issues is conducted during the next regularly scheduled review, and implementation of recommendations is strictly voluntary. Compliance issues, however, would

require the development of a corrective action plan, with deadlines for implementation, and a follow-up site visit to verify implementation.

a. All nine workforce regions and special projects are reviewed on-site on an annual basis; the Rural Consortium review consists of a sample of the ten subregions. In addition, the Rural Consortium conducts internal reviews of all of its subregions. The Department will revise its monitoring policy to include a monitoring plan that addresses how it monitors the Rural Consortium and provide more specifics as to the monitoring process and its frequency.

b. Financial desk reviews are conducted on an ongoing basis. The Department will conduct on-site financial reviews every two years; on-site financial reviews are generally conducted as part of overall financial monitoring. The last regularly financial review was conducted two years ago as part of Job Training Partnership Act (JTPA) monitoring activities. In addition, each of the nine regions is subject to an independent financial audit under the Single Audit requirement. Each region is required to monitor its subcontractors.

c. The Department requires in its unified contracts that each workforce region will monitor its subrecipients at least annually. The monitoring policy will be revised to provide more specifics in this area.

d. Workforce regions are required, as a condition of its unified contract with the Department, to follow up on any recommendations, and to comply with all policy guidance issued by the Department. The Department ensures that any recommendations it makes to a workforce region as a result of monitoring activity are followed up during technical assistance reviews and the next regularly scheduled review; however, it should be noted that if the issue does not involve a compliance issue, acceptance and implementation of these recommendations is voluntary and open to negotiation. The Department will revise its monitoring policy to provide more specifics regarding the follow up of recommendations that do not require corrective action.

Regions Should Improve Documentation Maintained in Client Files

As part of their contract with the Department, regions are required to maintain records on each client's involvement in WtW. These records, at a minimum, must contain information on dates of entry, eligibility, participation, and termination. In some of the regions we visited, we identified problems with information maintained on the WtW clients. We particularly found deficiencies with client files maintained by the Denver and Arapahoe/Douglas regions. In many cases it was difficult to determine the types of services provided and employment history for several clients in our sample because of limited documentation. Specifically:

- **Many client files maintained by the Denver Region contained little or no information on services provided to these clients and their employment activities.** The Denver Region maintains four different files on each client. These files are kept in several different locations, including community-based organizations located throughout the city. During the audit we reviewed all files for each client in our sample and still found it difficult to obtain complete information on clients' participation in the program. For instance:

  – Almost 50 percent of the files reviewed from the Denver Region did not contain the beginning wage information on the client's most current job.

  – Nearly 70 percent did not contain current wage information on the client's most recent job.

  – About 60 percent did not contain documentation on the duration of the client's most current job.

- **Missing information in the client files in the Arapahoe/Douglas Region made it difficult to identify the types of services provided to clients and determine the client's success in the program.** Assessments and case notes maintained in the files from this region were often vague. Without complete and descriptive case notes, it can be difficult to identify the services provided to the client and the client's success in the program. The Department recommended in April 2000 that Arapahoe/Douglas ensure that contractors improve client files. The Department's monitoring report stated that "the portions of the files completed by the contractors were of an inconsistent quality." On the basis of our review of client files in Arapahoe/Douglas, this recommendation has not been implemented.

The Department needs to develop methods that will assist the regions with collecting and maintaining data so that program outcomes and effectiveness can be evaluated and monitored. At a minimum, regions should maintain the following types of information on each client:

- The date the client entered the program.
- Criteria used to establish eligibility.
- Demographic information, such as age, gender, ethnicity, and family status.
- Co-enrollments in other programs, including descriptions on how the case manager ensures that duplication of services is not occurring.
- All services provided to clients, including a brief description of the service and the date the service was provided to the client.
- Employment information, including a listing of all jobs held by the client while in the program, positions held by the client in each job, duration in each job, beginning and most current wages, performance in the jobs, and reasons why the client left jobs, if applicable.
- Child support information for noncustodial parents, including the personal responsibility contract, the client's monthly child support obligation, the amount in arrears, and all payments made by the client while in the program.
- Case notes that describe major activities or events related to the client.
- The date and reason the client was terminated from the program.

(CFDA No. 17.253)

Recommendation No. 84:

The Department of Labor and Employment should ensure that workforce regions are maintaining complete and accurate records on Welfare-to-Work clients by:

a. Providing guidance to the regions on the types of information that should be maintained in the client files.

b. Monitoring client files at least annually to ensure all required information is in the files.

Department of Labor and Employment Response:

Agree. The Department is already conducting these activities, and has since the program's inception (e.g., PGL 99-04-WW1, Welfare-to-Work Applicant Procedures, issued February 3, 1999; PGL 00-29-WW1, Welfare-to-Work Eligibility, issued December 1, 2000 to replace PGL 99-13-WW1, issued July 1, 1999).

a. The Department has issued policy guidance letters that address the issue of documentation and establish minimum standards; these policies are updated on an as-needed basis. The automated system has built-in edit checks that highlight missing required data elements. The Department will convene a workgroup of state partners and local workforce regions to discuss data collection and documentation needs, and determine whether additional standards are required.

b. The annual on-site reviews include a review of client files and case notes.

Department of Military Affairs

Introduction

The Department of Military Affairs consists of the National Guard and the Civil Air Patrol. The Adjutant General is the administrative head of the Department and the Chief of Staff of the Colorado National Guard. The Department is responsible for providing day-to-day command and control, guidance, policies, and administrative and logistics support to the Divisions of the National Guard and Civil Air Patrol.

The following comments were prepared following audit work performed at the Department of Military Affairs by the Office of the State Auditor staff in cooperation with staff from the firm of Cottrell & Associates. Please refer to page 63 in the Financial Statement Findings section for additional background information.

Fiscal Responsibility Is Needed

The Department has had significant accounting issues over the past few years and there continue to be significant turnover of accounting staff, delays in processing vendor payments, obtaining federal approvals for reimbursement, and recording additions and deletions to fixed assets. We conclude that the Department needs to make improvements in its systems and controls to ensure that assets are safeguarded and that accounting for transactions is timely and accurate. Please refer to Recommendation No. 15 in the Financial Statement Findings section for additional details, our recommendation, and the Department's response.

Improve the Recording and Reporting of Transactions

A shortage of accounting staff created additional risk that transactions may have been recorded improperly on the State's accounting system. Vendor payments lagged during the year, exceeding the 45 days allowable under the law. The Department has not updated the State's accounting system for changes in its land, buildings, and construction in progress since Fiscal Year 1999. During Fiscal Years 2000 and 2001 the Department expended about $3.7 million in controlled maintenance, land purchases, and construction

costs on armories and other buildings but was unable to provide information on the amount of these costs that should be capitalized. Please refer to Recommendation No. 16 in the Financial Statement Findings section for additional details, our recommendation, and the Department's response.

Department of Public Health and Environment

Introduction

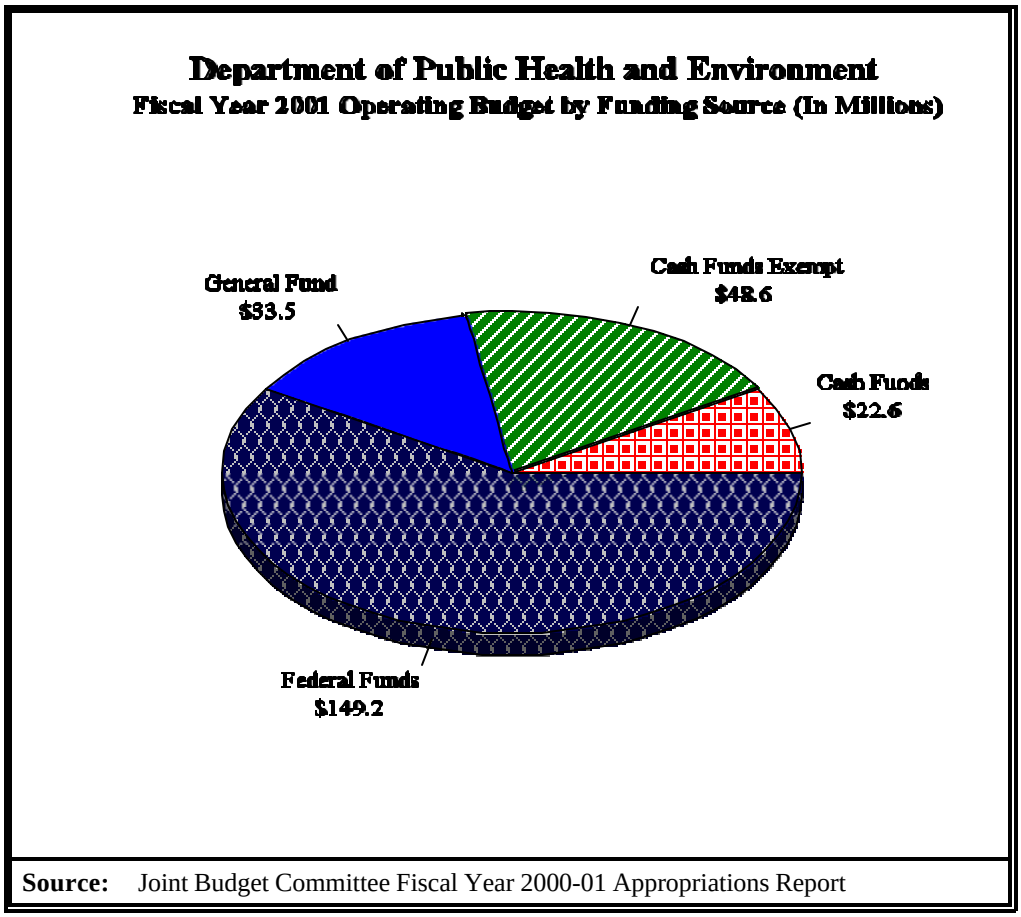
The Department of Public Health and Environment is responsible for improving and protecting the health of the people of Colorado, maintaining and protecting the quality of Colorado's environment, and assuring the availability of health and medical care services to individuals and families. The Department is composed of the following major organizational units:

- Administrative Divisions
  - Administration and Support
  - Center for Health and Environmental Information
  - Laboratory and Radiation Services
  - Local Health Services

- Environmental Divisions
  - Air Quality Control
  - Water Quality Control
  - Hazardous Materials and Waste Management
  - Consumer Protection

- Health Services Divisions
  - Disease Control and Epidemiology
  - Family and Community Health Services
  - Health Facilities
  - Emergency Medical Services and Prevention
  - Prevention and Intervention Services for Children and Youth

The Department was appropriated $253.9 million and 1,079.5 full-time equivalent staff (FTE) for Fiscal Year 2001. The following chart shows the operating budget by funding source during Fiscal Year 2001.



Source: Joint Budget Committee Fiscal Year 2000-01 Appropriations Report

Home and Community Based Services and Home Health Services Overview

As an alternative to nursing facility care, Medicaid-eligible individuals who meet the functional assessment for needing nursing facility level of care can choose to receive supportive services in their home or an alternative living environment outside of a nursing facility. These supportive services are provided to individuals through the Home and Community Based Services (HCBS) and the Home Health programs. Please refer to page 159 for additional background information.

Oversight of Home Care Providers

Clientele served by the HCBS and Home Health programs are typically elderly, disabled, frail, or in need of nursing facility placement and, therefore, are considered a vulnerable population. Services provided by the Home Health and HCBS programs are provided to clients in their homes and communities, and thus, provider staff often have unsupervised contact with vulnerable persons. The Home Health program offers skilled care, such as insertion of catheters and collection of blood samples, to clients. In contrast, HCBS programs provide unskilled care, such as housekeeping and meal preparation, to clients.

The Health Facilities Division (the Division) within the Department of Public Health and Environment monitors the quality of care provided by Home Health (skilled) and Home and Community Based Services (HCBS unskilled) providers by performing unannounced inspections, or surveys, to ensure providers' compliance with participation requirements. The federal Health Care Financing Administration (HCFA) has established quality of care and administrative standards that home health (skilled) providers must meet in order to become "certified" to receive Medicaid or Medicare reimbursement for services provided. According to federal rules, home health providers are required to be surveyed every 12 to 36 months based on their performance (e.g., number of complaints received, results of the prior survey, changes in management).

The Department of Health Care Policy and Financing (HCPF) established standards that HCBS (unskilled) providers must meet in order to become "certified" to participate in these programs. HCPF requires that the Division survey these providers every 9 to 15 months in order to ensure that standards are met.

Providers (both HCBS and Home Health) who do not comply with established standards are cited with deficiencies. There are 131 certified home health providers and a total of 440 HCBS service providers certified by the Division, including 126 personal care/homemaker providers, 42 HCBS adult day care providers, and 272 HCBS alternative care facility providers.

We reviewed the Division's oversight of quality of care provided by home health, personal care/homemaker, and adult day care providers. We did not review the Division's certification activities as they relate to certifying alternative care facility providers. We noted issues with oversight for both the Home Health and HCBS programs and, as a result, have concerns about whether certified providers are meeting standards and the impact of this on the quality of care being provided to program participants.

During Fiscal Year 2001 the Office of the State Auditor conducted a performance audit of Home and Community Based Services and Home Health Services. The audit comments below were contained in the *Home and Community Based Services and Home Health Services*, Report No. 1033, dated June 2001.

Survey Process Needs to Be Improved

As part of our audit, we reviewed a sample of 30 Health Facilities Division surveys (on-site inspections) of home health providers conducted during Fiscal Years 1999 through 2001. We also reviewed a sample of 23 HCBS surveys conducted during Fiscal Years 2000 and 2001. We identified the following problems:

- **Surveyors failed to consistently and adequately cite deficiencies.** During our review we noted that surveyors inconsistently cited a deficiency related to inadequate supervision of home health aides for eight providers. In three reviews the deficient practice was noted as occurring in 33 to 83 percent of the sample, and deficiencies were cited at the least severe deficiency level. However, the same deficiency was cited in five other reviews (for a similar percentage of the survey sample), and surveyors cited more severe deficiencies. We also found that in four of our HCBS sample items, surveyors marked items "not met" but did not cite a deficiency. In these four cases sample documentation indicated deficient practices for between 18 and 80 percent of the records reviewed, yet deficiencies were not cited. According to Division surveyors, providers may offer explanations or additional documentation, indicating substantial compliance with standards. However, we did not find evidence of this during our review. Deficiency citing is key to ensuring providers correct quality of care issues; therefore, it is critical that surveyors identify potential deficiencies and cite them appropriately.

- **Surveyors failed to adequately document inspection results.** During our review of survey documentation we found that required documents were frequently missing or incomplete. For example, we found that the Division could not locate several important survey documents and surveyors did not complete all required documentation, including forms that assist surveyors in determining the appropriateness of the provider's care and services, records supporting that surveyors conducted review of personnel and client records, and the plan of correction and forms used to indicate whether plans of correction are adequate. Without adequate documentation the risk is increased that deficient practices are not identified.

Due to the problems we noted with surveyors' reviews of home health providers' personnel records, we performed our own review of personnel records to ensure that staff have appropriate licensure or certification. In our review of six providers' personnel records we found two expired physical therapists' licenses and one expired speech therapist certification. In addition, one provider was unable to produce personnel records for a licensed practical nurse or for any of the provider's therapists. Although we were able to verify current licensure and certification through other means, Medicare standards require that personnel records include current documentation of licensure and certifications.

- **Surveyors failed to select adequate sample sizes.** For nine of our home health and four of our HCBS samples surveyors failed to select the federally and Division-required number of clients to include for record reviews, home visits, and interviews. For these surveys surveyors selected up to four items fewer than the policies required. Without adequate sample sizes, the risk is increased that surveyors will not identify a quality of care issue.

We compared the average number of hours spent on surveys in Colorado and the number of surveys conducted without deficiencies cited with regional data for home health surveys. (Because HCBS surveys are not currently a federal requirement, statistics on HCBS surveys are not available.) We found that Colorado surveyors spend about a fourth less time, on average, on surveys than other states regionally. Additionally, over the past three years, an average of 66 percent of home health surveys conducted in Colorado did not contain any cited deficiencies. This exceeds the average of other states regionally by 20 percent. When this information is viewed along with the data already presented, questions are raised about the effectiveness of Colorado's survey process in identifying providers' noncompliance with standards. Therefore, this also raises concerns about the quality of care offered by home health providers. Additionally, the types of problems found with HCBS surveys indicate that the HCBS review process also needs improvement.

Increased Supervision and Improved Evaluations Are Needed

The survey process is the Division's main method for identifying quality of care issues with home health and HCBS providers. Therefore, it is essential that surveyors follow procedures completely and maintain adequate documentation to support conclusions and ensure that deficient practices are identified and corrected. The Division can improve its survey process as explained below.

Increased supervision. Although program management performs a quality assurance review of deficiency lists prepared by surveyors, this does not include a review of supporting documentation to ensure that appropriate checklists and other types of required paperwork were completed, or that adequate sample sizes were used. Performing a more thorough review of survey materials would help reduce the occurrence of the problems noted earlier.

Revised performance evaluations. The Division uses a general performance evaluation process for its surveyors. We recommend reevaluating this process and establishing specific performance measures regarding completeness, adequacy, and appropriateness of survey procedures performed. Adding these types of factors to evaluations may encourage surveyors to improve the quality of their work.

Recommendation No. 85:

The Health Facilities Division should improve the home health and HCBS survey process by:

a. Requiring supervisors to review survey documents in entirety on a random basis to ensure completeness, adequacy, and appropriateness of the procedures performed.

b. Ensuring that surveyor performance evaluations include performance measures that address the completeness, appropriateness, and adequacy of surveys completed.

c. Improving record-keeping to ensure that all necessary documentation supporting survey procedures and conclusions is maintained.

Health Facilities Division Response:

Agree. The Health Facilities Division will make improvements to the home health and HCBS survey process as follows:

a. The supervisor's performance plan for Fiscal Year 2002 includes performance measures regarding supervision of home health and HCBS surveyors while they are in the field conducting the surveys and review of completed survey packets.

b. The surveyors' performance plans for Fiscal Year 2002 include performance measures regarding the completeness, appropriateness, and adequacy of the surveys they complete.

c. The Division has taken a multi-pronged approach to implementing this part of the recommendation. (1) Earlier this year, the Health Facilities Division sought and received approval to hire a full-time records manager, and is in the process of hiring an individual for this position. Once hired, this person will implement policies and procedures for collecting and maintaining documentation related to the survey process. We anticipate this to be complete by December 31, 2001. (2) As an interim measure, the Division is currently using temporary staff to review completeness of survey packets prior to their filing. (3) The Division has revised some of the forms used to collect the survey data to ensure it is clear to surveyors and reviewers which data is mandatory and which is optional.

Improve Risk-Based Scheduling of Surveys

Home health and HCBS survey scheduling requirements are shown in the following table.

Survey Scheduling Requirements		
	Home Health (Skilled)	**HCBS (Unskilled)**
Survey Frequency	12 to 36 months	9 to 15 months
Federally or State Required	Federal and State	State
Risk-Based	Yes	No
Required Follow-Up Survey for Severe Deficiencies	Yes, 4 to 6 months after deficiency was corrected	No

Source: OSA analysis of information provided by the Health Facilities Division.

During our audit we found that the Division needs to improve its survey scheduling. Specifically, we found:

- **Home health (skilled) providers were not consistently surveyed within required time frames.** According to HCFA regulations, home health surveys must be conducted on a risk-based schedule. However, we found that the Division failed to survey 26 of 127 (20 percent) home health providers within

federally required time frames. Three of these providers had more severe deficiencies that made them high-risk and, therefore, should have been reviewed within six months of correcting their deficiencies. As of the end of our fieldwork, surveys for these providers were approximately one to three months late. Health Facilities Division staff indicated that criteria for the four- to six-month survey requirement for providers with more severe deficiencies were not built into the Division's survey cycle assignment and tracking system, thus, the system does not identify these providers.

We also found that other home health (skilled) providers were reviewed more frequently than necessary. Although surveyors may use their judgment and assign a provider to a more frequent survey cycle, reasons for assigning specific cycles are not documented, and regular review of the appropriateness of cycles is not performed. Health Facilities Division staff indicated that there does not appear to be any reason precluding these providers from being on a less frequent cycle. This is important because the Division reports that it is understaffed; therefore, resources could have been used more effectively toward surveying higher-risk providers.

- **Risk-based monitoring of HCBS providers is not conducted.** Currently the Department of Health Care Policy and Financing requires the Division to survey HCBS (unskilled) providers every 9 to 15 months. However, we found that additional efficiency could be achieved by conducting HCBS surveys using a risk-based approach. As indicated in the table, home health (skilled) providers are surveyed on a risk-based cycle and both Home Health and HCBS programs have a similar risk to clients, since services are provided in clients' homes. Therefore, it is not effective or efficient to perform more frequent surveys of HCBS providers than home health providers. In addition, we found that for the most recent surveys of 167 HCBS providers 62 (37 percent) were not conducted within 15 months of the previous survey. The Division cannot meet the 9- to 15-month time frame for surveying these providers. As part of a risk-based cycle, providers with complaints or past noncompliance issues should be surveyed more frequently, and the Division should perform desk reviews of policies and procedures and staff licensure, certification, and training for providers in years that an on-site survey is not conducted.

Timely Resurveying of New HCBS Providers Is Necessary

During a routine survey of HCBS providers, surveyors look for adequacy of policies and procedures and review client and staff personnel records. However, in some cases new

HCBS providers do not have clients or staff at the time of the survey. In these situations the surveyors recommend certification based on review of the providers' policies and procedures. Providers are then instructed to contact the surveyor when they have staff and clients, and then the surveyor will revisit the provider to review these records. Providers, however, do not always call the surveyor once they have hired staff and are serving clients. Therefore, a full survey of the provider may not be conducted until 15 months or more after the initial certification. This is a concern because deficient practices related to client records and staff qualifications may not be detected and corrected timely.

Recommendation No. 86:

The Health Facilities Division should ensure that providers are surveyed timely and efficiently by:

a. Adding a four- to six-month cycle to the survey scheduling and tracking database for home health providers with more severe deficiencies.

b. Requiring surveyors to document reasons for assigning survey cycles.

c. Performing regular reviews of assigned cycles for appropriateness.

d. Resurveying new HCBS providers after the providers admit clients to ensure that all standards are met.

Health Facilities Division Response:

Agree. The Health Facilities Division agrees with the recommendation and is in the process of implementing it as follows:

a. The task of changing the survey scheduling system to allow four- to six-month survey cycles for home health surveys has already been assigned to the Division's information systems and support team. They currently anticipate having such changes made no later than December 31, 2001.

b, c. The Division has developed and implemented a new form on which the surveyor must explain the rationale behind the particular survey cycle selected. The completion of this form and assignment of the provider to the appropriate survey cycle will be ensured through the supervisor's review of

survey packet completion as discussed in our response to Recommendation No. 85.

d. The Division is in the process of implementing a change in procedure for surveying new HCBS Personal Care/Homemaker providers. Prior to admission of clients, the surveyors will perform an off-site paper review of the provider for the purpose of initial certification and will perform an on-site review of the provider once they have admitted clients. Due to having different program requirements, the HCBS Adult Day Care initial certification process will continue to include an on-site visit. A follow-up on-site survey for Adult Day Care providers will also be conducted once the provider admits clients. We anticipate the changes to be implemented no later than October 31, 2001.

Adequate Documentation Supporting Deficiency Deletions Is Not Maintained

Under the Division's processes, deficiencies may be changed or deleted through a quality assurance or informal review. Quality assurance reviews of deficiency lists are performed by program management to ensure that sufficient evidence exists to support the deficiencies and that appropriate deficiencies were cited. Informal review is a process available to providers if they dispute a deficiency citing. A committee reviews evidence about the deficiency and makes a recommendation to Division management regarding whether enough evidence exists to support the deficiency or if the deficiency should be deleted. Health Facilities Division management has the final approval before a deficiency is deleted. This process is federally required for nursing facilities but not for home health providers. However, in an effort to standardize procedures, the Division makes this process available to all providers that it surveys.

We found that adequate documentation was not maintained to support changes or deletions to deficiency lists for two home health providers.

- **A federal survey form included four deficiencies that were not included on the provider's final deficiency list or reported to HCFA.** Health Facilities Division staff could not explain why these deficiencies were not included in the final provider survey records. As a result, the provider did not respond to the deficiencies with a plan of correction. The deficiencies were for standards on

administrator functions, registered nurse supervision of services provided, personnel contract elements, and licensed practical nurse services.

- **A deficiency, originally upheld by the Informal Review Committee, was later deleted.** The Health Facilities Division provided us with documentation indicating that the informal review committee originally agreed with the deficiency cited and that it should not be deleted. However, according to Health Facilities Division staff, a second review was conducted by Division management that resulted in the deletion of the same deficiency. This deficiency was for a standard related to the existence and appropriateness of personnel polices and current licensure and qualifications of provider staff. The Division was unable to provide us with documentation that described why management felt the deficiency should be deleted after the Informal Review Committee supported the deficiency.

Deficiency citing is essential to correcting quality of care issues. Without adequate documentation for deleting deficiencies, the risk is increased that inappropriate changes are made. Our concern with changes to deficiency lists is heightened due to staff turnover and because Health Facilities Division staff indicate that previous management would sometimes delete deficiencies without recommendation from the informal review committee. These practices could put the State at risk for being in violation of federal requirements to report home health deficiencies properly. Therefore, the Division needs to ensure that adequate documentation is maintained when any changes to deficiency lists are made.

Recommendation No. 87:

The Health Facilities Division should ensure that adequate documentation is maintained when changes are made to providers' deficiency lists. This documentation should include who is making the decision and the basis for making changes.

Health Facilities Division Response:

Agree. The Health Facilities Division is developing a policy for retention of documentation related to changes in deficiency lists to ensure such documentation is consistently maintained. This policy should be finalized no later than December 31, 2001.

Clarify Whether Scope and Severity Coding Is Appropriate for Home Health Deficiencies

Currently all deficiencies noted by home health surveyors are coded as to scope and severity. Scope and severity codes are assigned to deficiencies based on two factors: the potential for harm (ranging from potential for minimal harm to actual or potential for death or serious injury) and the prevalence of the deficiency (ranging from isolated to widespread). For example, the "A" level scope and severity code means that the deficient practice had potential for minimal harm and was isolated in occurrence. In contrast, an "L" level code means that the deficiency caused or had potential to cause death or serious injury and was widespread in occurrence. This coding is federally-required for deficiencies cited against nursing facilities, and in order to standardize policies and procedures, the Division implemented the use of scope and severity coding for all providers that it surveys. However, federal home health rules do not dictate the use of scope and severity, and on the basis of discussions with HCFA staff, this coding should not be used for home health deficiencies.

The Division's use of scope and severity is a problem because providers with an "A" scope and severity level deficiency are not required to respond to the deficiency with a plan of correction and the deficiency is not reported to HCFA. We found that Division surveyors cited "A" level deficiencies 31 times in 131 providers' most recent surveys. These deficiencies related to inadequate supervision of aides, drug regimen review, and clinical record content. None of these deficient practices were addressed by a plan of correction or reported to HCFA.

Recommendation No. 88:

The Health Facilities Division should work with the federal Health Care Financing Administration to clarify whether scope and severity coding is appropriate for home health deficiencies.

Health Facilities Division Response:

Agree. As the auditors mention, HCFA does not require and does not appear to agree with the use of scope and severity coding for home health deficiencies.

Therefore, beginning in May 2001, the Health Facilities Division discontinued reporting scope and severity related to home health deficiencies. This change eliminated the designation of an "A" level deficiency, thus requiring home health agencies to provide the Division with a plan of correction for all deficiencies cited. We will follow up with HCFA to ensure that this course of action will meet their needs no later than October 31, 2001.

Office of the State Treasurer

Introduction

The Office of the State Treasurer is established by the State Constitution. The Treasurer is an elected official who serves a four-year term. Please refer to page 119 in the Financial Statement Findings section for additional background information.

Cash Management Improvement Act

The Cash Management Improvement Act (CMIA) regulates the transfer of funds between federal and state agencies for federal grants. The CMIA regulations require the State to match the time between incurring expenditures of federal funds and requesting and receiving reimbursement. States are required to enter into a Treasury- State Agreement (Agreement) with the U. S. Treasury. This Agreement specifies the procedures that the State will follow to carry out transfers of funds.

The State has just completed the second year of the current Agreement. The Agreement lasts five years (until Fiscal Year 2004) and may be modified by either party. In Fiscal Year 2001 there were 30 federal programs covered by CMIA at the Departments of Education, Health Care Policy and Financing, Human Services, Labor and Employment, Local Affairs, Public Health and Environment, and Transportation. These programs had expenditures of more than $2 billion in Fiscal Year 2001.

Each year an annual report must be submitted to the Financial Management Service (FMS) of the U. S. Treasury by December 31. This report details any interest liability that is owed by the State or federal government.

Maintain Documentation to Support Direct Cost Claim

The State is allowed to submit a direct cost claim to the federal Financial Management Service (FMS) to recover its direct costs for time spent by Treasurer's Office personnel coordinating the State's CMIA efforts. The amount of this claim is netted against any

interest liability owed by the State to the federal government. Federal cost principles require that a direct cost claim be adequately documented and available.

During our audit we found that the Treasurer's Office is not maintaining documentation to support the State's direct cost claim of $13,316. The instructions provided by the FMS for completing the claim require adherence to the cost principles of federal OMB Circular A-87. These principles require that records should be kept to support costs charged to the federal government.

Without adequate supporting documentation, the State's direct cost claim is not auditable and is not in compliance with OMB Circular A-87. If the claim is not properly supported by adequate documentation, it may be disallowed by the FMS. If the claim is disallowed, the State would not be able to net the amount against any interest liability owed to the federal government and would have to pay the full amount. Therefore, the Treasurer's Office should keep records of the time spent implementing CMIA in order to support the State's direct cost claim.

Recommendation No. 89:

The Treasurer's Office should comply with CMIA regulations by maintaining proper documentation to support the State's direct cost claim.

Treasurer's Office Response:

Agree. Treasury will ensure that proper documentation is maintained to support the State's direct cost claim.

Department of Transportation

Introduction

The Colorado Department of Transportation is responsible for programs that impact all modes of transportation. The following comments were prepared by the public accounting firm of Arthur Andersen LLP, who performed audit work at the Department of Transportation. Please refer to page 127 in the Financial Statement Findings section for additional background information.

Perform Federally Required Employee Interviews on a Timely Basis

Department of Transportation Form #280 is both an Equal Employment Opportunity (EEO) and labor compliance form. The federal Davis-Bacon Act requires that all laborers and mechanics employed by contractors and subcontractors that work on federally funded construction contracts in excess of $2,000 must be paid prevailing wage rates as established for the locality of the project. The form is used when interviewing employees of prime contractors and subcontractors in order to verify employees are aware of the EEO requirements and are receiving the correct wages for the classification in which they are working.

Contractor and subcontractor employee payroll interviews and the Form #280 are not being completed in a timely manner. We performed 10 separate site visits and encountered issues with delayed completion of Form #280 to various extents at 6 of these sites. Lack of resources in the field has resulted in delays in the completion of these interviews. Failure to perform timely Form #280 interviews may result in the Department not being in compliance with Office of Management and Budget (OMB) Circular A-133, as required for all nonfederal entities receiving federal awards.

This is a problem that was first addressed in our Fiscal Year 1999 audit. The Department trained project engineers in the purpose and requirements of the Form #280 and required its regional Equal Employment Opportunity (EEO) representatives to take an active role in monitoring the quantity, quality, and timeliness of forms completion. The Department

should take further action and implement monthly monitoring procedures to ensure that it is in compliance with these federal requirements. (CFDA No. 20.205)

Recommendation No. 90:

The Department of Transportation should implement procedures that require field engineers to provide written communication to region supervisors of the number of interviews performed, as well as anticipated future interviews.

Department of Transportation Response:

Agree. The Department is currently reviewing the payroll certification process to better define the number of interviews required and to establish a reporting system. Implement June 30, 2002.

Implement Monitoring Procedures for Contractor Payments

We performed testing of payment procedures of 37 different pay items at 10 sites. We noted three errors related to contractor payment process and entry of information into the pay system. Two of the errors resulted in underpayments to certain contractors of about $500. The third error was detected prior to payment; however, if the transaction would have been processed, it would have resulted in an overpayment of about $12,500. These errors primarily resulted from human error in the calculation of amounts due and the subsequent entry of such amounts into the pay system. The Department's guidelines require that payments to construction contractors be based on invoices and that all calculations be reviewed and authorized by field engineers. All payments should be adequately reviewed to prevent errors in amounts paid. Field staff needs to prioritize monitoring and review of entries to the pay system and payments to contractors.

Errors in payments made on construction contracts may result in over- or under-payment to contractors. In addition, significant errors could result in the Department being in violation of federal compliance requirements. Independent review of invoices and calculations on which payments are made would detect any potential misstatements resulting from errors in the calculation and entry of amounts due to contractors. (CFDA No. 20.205)

Recommendation No. 91:

The Department of Transportation should design, document, and implement procedures providing for the formal monitoring and review of entries to the pay system and payments made to contractors on a monthly basis.

Department of Transportation Response:

Agree. Payment procedures are established to ensure timely and accurate payment of contractors. Field staff will be instructed to follow these procedures in processing contractor invoices. Implement December 31, 2001.